STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345237	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARBOUR COURT NURSING AND REHABILITATION CENTER	515 BARBOUR ROAD SMITHFIELD, NC 27577

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E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 10/14/20. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# VJY211	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey, complaint investigation and an on site revisit survey was conducted from 10/12-14/2020. The facility was found not to be in compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19 because a repeat citation of tag 880. The new tags that were cited were F580, F600, F641 and F656. The facility remains out of compliance. Four of thirty-three complaint allegations were substantiated resulting in deficiencies. Event ID#VJY211 Substandard Quality of Care was identified at: CFR 483.12 at tag F600 at a scope and severity (H) A partial extended survey was also conducted on 10/26/2020. Therefore the exit date was changed to 10/26/2020.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (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-	F 580		11/3/20

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

Electronically Signed | 11/03/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 580	Continued From page 1	F 580		

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(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);
(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
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(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.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
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

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F 580	Continued From page 2 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). This REQUIREMENT is not met as evidenced by: Based on staff, nurse practitioner, and physician interviews and record review the facility failed to notify the physician or nurse practitioner of a change in wound condition for 1 of 2 residents reviewed for pressure ulcer care. (Resident #1) Findings included: Resident #1 was admitted to the facility on 7/13/19. Resident #1's active diagnosis included anemia, atrial fibrillation, hypertension, gastroesophageal reflux disease, renal insufficiency (renal failure, or end stage renal disease), diabetes mellitus, hyperlipidemia, thyroid disorder, Alzheimer's disease, cerebrovascular accident, dementia, Tourette's syndrome, anxiety disorder, depression, psychotic disorder, schizophrenia, asthma, and temporal sclerosis. A review of Resident #1's minimum data set assessment dated 7/1/2020 revealed she was assessed as severely cognitively impaired. She was assessed to have no pressure ulcers at that time. A review of Resident #1's care plan dated 7/20/2020 revealed she was not care planned for the presence of pressure ulcers. Review of a wound care note by the wound care nurse dated 6/11/2020 revealed two stage 2 pressure ulcers were found on Resident #1's	F 580	Barbour Court Nursing and Rehabilitation 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. Barbour Court Nursing and Rehabilitation 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, Barbour Court Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F580 Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) Resident #1 no longer resides at the facility. On 10/14/20, the Director of Nursing (DON) and Facility Consultant initiated a 100% audit of residents with wounds to ensure the medical provider has been updated on wound status changes and/or	

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F 580	Continued From page 3 buttock. Treatment was implemented and the responsible party was notified. Frequent turning was recommended while in bed. Limited time up in wheelchair was also recommended. Review of Resident #1's physician's orders revealed on 6/11/2020 orders to clean the two pressure ulcers to the right buttock with normal saline or wound cleaner, apply sorbalgon Ag silver (a soft, but highly absorbent latex-free calcium alginate dressing which contains silver, that quickly forms a non-adhering water attracting gel to protect and cover the wound bed, while maintaining a moist wound healing environment) and cover with a dry dressing daily. This order was unchanged until 8/10/2020 when Resident #1 was discharged to the hospital. According to the record, the wound did not resolve prior to this discharge. Review of the treatment record for Resident #1 for June through August of 2020 revealed Resident #1 was not documented to have received wound care on 6/12, 6/19 through 6/21, and 6/26 through 6/30. There was no treatment record documentation for July 2020. In August 2020 Resident #1 was not documented to have received wound care on 8/1 through 8/3, 8/5, 8/8, and 8/9. She was then discharged on 8/10. Review of a wound assessment dated 6/11/2020 revealed pressure ulcer #1 to Resident #1's buttock measured 2.5 centimeters by 0.5 centimeters with less than 0.1 centimeters of depth. Pressure ulcer #2 measured 1.0 centimeters by 0.5 centimeters with less than 0.1 centimeters of depth. They were both documented as stage II pressure ulcers with scant amounts of serosanguineous drainage. The	F 580	wounds that fail to progress. The Director of Nursing will address all areas of concern identified during the audit to include notification of the physician for further instructions/orders for treatment. Audit will be completed by 11/3/20. On 10/15/20, the facility initiated weekly wound meetings to include DON, treatment nurse, Unit Manager; Dietary Manager and Minimum Data Set nurse (MDS) to review all current wound assessments/treatments, wound status and to ensure the physician and/or medical provider has been notified of new, worsening or wounds that are not progressing with current therapy. The medical provider will review and initial the wound meeting minutes weekly to validate notification. On 10/14/20, 100% in-service was initiated by the Human Resource Coordinator (HRC) with all nurses in regards to Notification of Changes with emphasis on notification of physician/resident representative (RR) with any change in resident condition to include but not limited to changes in wound status with documentation in the electronic record. In-service will be completed by 11/3/20. All newly hired nurses will be in-serviced by the HRC during orientation in regards to Notification of Changes. The Unit Managers, Nurse Supervisor and/or Minimum Data Set Nurse (MDS) will review ten (10) charts of residents with wounds weekly x 8 weeks then monthly x 1 month utilizing the Wound Audit Tool. This audit is to ensure the physician/RR	

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F 580	Continued From page 4 wound beds were red, granular tissue. There was no documentation on pressure ulcer #2 after 6/11/2020. Review of a wound assessment dated 6/17/2020 revealed pressure ulcer #1 to Resident #1's buttock was measured. This wound was 0.4 centimeters by 1.0 centimeters with no depth. There was no drainage noted and the wound bed had a light brown scab. Review of a wound assessment dated 6/24/2020 revealed pressure ulcer #1 measured 1.2 centimeters by 0.2 centimeters and was a stage II pressure ulcer. It had scant amounts of serosanguineous drainage, dry red granular tissue on wound bed, and the area around the wound was emaciated. A review of the wound assessments and nursing notes revealed there were no wound care measurements or notes for the pressure ulcer to her buttock from 6/24/2020 through 7/30/2020. Review of a wound assessment dated 7/30/2020 revealed pressure ulcer #1 now measured 6 centimeters by 10 centimeters. It was documented now as a suspected deep tissue injury. The wound had moderate amounts of serosanguineous drainage. It was documented the physician was notified of this wound. Review of a wound note dated 8/6/2020 revealed pressure ulcer #1 had 75% deep tissue injury, 25% granulation tissue, and moderate amounts of serosanguineous drainage from the wound. The wound care nurse documented no signs or symptoms of infection to the area.	F 580	was notified of wound status changes or failure for wound to progress for further instructions/orders. The Unit Managers, Nurse Supervisor and/or MDS nurse will address all areas of concern identified during the audit to include assessment of the resident, notification of the physician/RR of wound status changes and re-training of staff. The DON will review the Wound Audit Tool weekly x 8 weeks then monthly x 1 month to ensure all areas of concern were addressed. The DON will present the findings of the Wound Audit Tool and the Weekly Wound Meeting Minutes to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. The Executive QAPI Committee will meet monthly for 3 months and review the Wound Audit Tool and the Weekly Wound Meeting Minutes to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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Review of a nurse practitioner's visit note dated 8/10/2020 revealed Resident #1's nurse practitioner saw Resident #1 on 8/10/2020. She documented staff requested resident be seen for continuing decline with poor meal intake. Resident #1 showed continued evidence of physical and cognitive decline and due to this she was at high risk for developing pressure ulcers and weight loss among other complications. She ordered labs and had all medications held after assessment of the resident. Resident #1 was not awakened and was lying in bed with no distress. The Nurse Practitioner did not mention the pressure ulcer.

The facility's wound care nurse no longer worked at the facility and was unavailable for interview after multiple attempts to contact her.

During an interview on 10/12/2020 at 10:42 AM Nurse #1 stated she remembered Resident #1. She stated the treatment nurse would perform treatment for Resident #1 and she would change the dressing as needed if it became soiled or came off during her shift. She stated she thought she changed the wound dressing once. She stated when she cared for Resident #1 the wound on her coccyx was about 3 inches by 3 inches of necrotic tissue with red around the edges. She stated she did not inform the physician of the wounds as that was the responsibility of the treatment team.

During an interview on 10/13/2020 at 10:03 AM, Nurse Practitioner #1 stated she was Resident #1's primary nurse practitioner. The Nurse Practitioner stated unless the treatment nurse informed her a resident's wounds were getting

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worse and needed a new order, she did not visualize the wounds. The nurse practitioner stated she did not think she visualized Resident #1's wound as the wound care nurse did not share any concerns about the wound deterioration with her. She stated the wound care nurse did not mention any concerns about the wound to Resident #1's buttock. She stated with a change in the wound status from 6/24/2020 to 7/30/2020 it would have been helpful to be informed. She concluded she did not remember the wound deterioration ever being brought to her attention.

During an interview on 10/13/2020 at 1:56 PM, Physician #1 stated he vaguely remembered the name of Resident #1 but did not remember her baseline condition in detail. He further stated he did not remember if it was ever brought to his attention that Resident #1 had pressure ulcers, but it was possible it was. He stated he did not recall being notified of any deterioration to the wound. He stated he did not recall visualizing the wound. He stated the nurses had a scope of practice and they had a protocol to follow. Resident #1 was clearly declining, and the outcome would not have changed with wound care, and therefore he did not feel it was critical the wound care nurse notified him about the deterioration of the wound. He stated with wounds it was always good to inform the nurse practitioner or physician of changes, however he did not believe it to be critical to inform in all cases including this resident who was declining.

During an interview on 10/13/2020 at 2:26 PM the Director of Nursing stated the treatment nurse should have notified the nurse practitioner or physician of the change in the wound condition.

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F 580	Continued From page 7 She stated the wound care nurse documented that she had notified the medical doctor and was unsure why it appeared the information did not reach them as the orders were never changed and both the physician and nurse practitioner did not indicate they were aware of the change. She stated any change in condition should trigger the nurse to notify the responsible party as well as the physician or nurse practitioner including wound changes even if the resident is declining. She stated when she came to the facility on 7/13/2020 she was informed there were wound concerns at the facility. She stated the assistant director of nursing was working with the wound care nurse because the wound care nurse had issues with measurements as well as what wound dressing products should be used. The facility had also identified the wound care nurses were not recognizing to request wound care order changes or request wound center appointments. She stated the facility had begun a plan of correction, but the plan of correction had not been completed as of 10/13/20.	F 580		
F 600 SS=H	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600		11/3/20

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F 600	Continued From page 8 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff, nurse practitioner, and physician interviews and record review the facility neglected to communicate, accurately track, document, assess and provide medical treatment as ordered for pressure ulcers on a resident's sacrum/buttocks area for 1 of 2 residents who was at high risk for wound development and experienced a significant change in wound condition (Resident #1). This resident's stage II pressure ulcer deteriorated to be an unstageable pressure ulcer, growing from 1.2 centimeters by 0.2 centimeters to 6 centimeters by 10 centimeters. Resident #1 was admitted to the hospital and was diagnosed with severe sepsis and the unstageable pressure ulcer to the sacrum. Findings included: Resident #1 was admitted to the facility on 7/13/19. Resident #1's active diagnosis included anemia, atrial fibrillation, hypertension, gastroesophageal reflux disease, renal insufficiency (renal failure, or end stage renal disease), diabetes mellitus, hyperlipidemia, thyroid disorder, Alzheimer's disease, cerebrovascular accident, dementia, anxiety disorder, depression, psychotic disorder, schizophrenia, and temporal sclerosis. A wound care note by the wound care nurse dated 6/11/2020 revealed two stage 2 pressure ulcers were found on Resident #1's buttock. Treatment was implemented and the responsible	F 600	F600 Free from Abuse and Neglect CFR(s):483.12(a)(1) Resident #1 no longer resides at the facility. On 11/2/20, the Facility Consultant completed a 100% audit of all Wound Ulcer Assessments 10/1-11/1/20. This audit was to identify any wounds that were not assessed per facility protocol with documentation of wound assessment/treatment and notification of physician (MD) and resident representative (RR) of wound status. The Director of Nursing (DON) and treatment nurse addressed all area of concerns identified during the audit to include assessment of the resident, initiating treatment orders based on assessment, notification of MD/RR of wound status and updating care plan/care guide. On 10/28/20, the Facility Consultant completed a 100% audit of Treatment Administration Records (TARs) from 10/1/20-11/1/20. This audit is to ensure all treatments were completed per physician orders. The Treatment nurse, assigned hall nurse and Unit Managers addressed all areas of concern identified during the audit to include assessment of the resident, notification of MD of treatment omission for further instructions and education of the nurse. On 10/28/20, the Director of Nursing initiated a 100% skin check of all	

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F 600	Continued From page 9 party was notified. Frequent turning was recommended while in bed. Limited time up in wheelchair was also recommended. Resident #1's physician's orders revealed on 6/11/2020 she was ordered to clean the two pressure ulcers to the right buttock with normal saline or wound cleaner, apply sorbalgon Ag silver (a soft, but highly absorbent latex-free calcium alginate dressing which contains silver, that quickly forms a non-adhering water attracting gel to protect and cover the wound bed, while maintaining a moist wound healing environment) and cover with a dry dressing daily. This order was unchanged until 8/10/2020 when Resident #1 was discharged to the hospital. The wound did not resolve prior to this discharge. A wound assessment dated 6/11/2020 by the wound care nurse revealed pressure ulcer #1 to Resident #1's buttock measured 2.5 centimeters by 0.5 centimeters with less than 0.1 centimeters of depth. Pressure ulcer #2 on the resident's buttocks measured 1.0 centimeters by 0.5 centimeters with less than 0.1 centimeters of dept. They were both documented as stage II pressure ulcers with scant amounts of serosanguineous drainage. The wound beds were red, granular tissue. There was no documentation on pressure ulcer #2 after 6/11/2020. A wound assessment dated 6/17/2020 completed by the wound care nurse revealed pressure ulcer #1 to Resident #1's buttock was measured. This wound was 0.4 centimeters by 1.0 centimeters with no depth. There was no drainage noted and the wound bed had a light brown scab.	F 600	residents. This audit is to identify any new skin concerns not currently being assessed/ treated or that the MD/RR has not been notified of concern. The Unit Managers, treatment nurse and assigned hall nurse will address all areas of concern identified during the audit to include assessment of the resident with documentation in electronic record, initiating treatment per facility protocol, and notification of the MD/RR. The audit will be completed by 11/3/20. On 10/15/20, the facility initiated weekly wound meetings to include DON, treatment nurse, Unit Manager; Dietary Manager and Minimum Data Set nurse (MDS) to review all current wound assessments/treatments, wound status and to ensure the physician and/or medical provider has been notified of new, worsening or wounds that are not progressing with current therapy. The medical provider will review and initial the wound meeting minutes weekly to validate notification. On 10/29/20, the facility provided additional training to the designated treatment nurse by a wound care nurse to include but not limited to assessment /treatment of wounds per facility protocol, notification of MD or medical provider of new, worsening or wounds that are not progressing with current therapy and documentation in electronic record. Beginning 10/30/20, the DON will complete Wound Rounds with Treatment Nurse weekly to ensure all wounds are assessed per facility protocol with appropriate documentation to include	

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F 600	Continued From page 10 A wound assessment dated 6/24/2020 completed by the wound care nurse revealed pressure ulcer #1 measured 1.2 centimeters by 0.2 centimeters and was a stage II pressure ulcer. It had scant amounts of serosanguineous drainage, dry red granular tissue on wound bed, and the area around the wound was "emaciated." The wound assessments and nursing notes revealed there were no wound care measurements or notes for the pressure ulcer to her buttock from 6/24/2020 through 7/30/2020. Resident #1's quarterly minimum data set assessment dated 7/1/2020 revealed she was assessed as severely cognitively impaired. She was assessed to have no pressure ulcers at that time. She required extensive assistance with bed mobility, transfers, locomotion on unit, dressing, eating, and personal hygiene. She was totally dependent on staff for toilet use. She was always incontinent of bowel and bladder. Resident #1's care plan dated 7/20/2020 revealed her pressure ulcer had not been addressed in the care plan. The treatment record for Resident #1 for June 2020 through July of 2020 revealed Resident #1 was not documented to have received wound care to her pressure ulcers on 6/12, 6/19 through 6/21, and 6/26 through 6/30. There was no treatment record documentation for July 2020. A wound assessment dated 7/30/2020 completed by the wound care nurse revealed pressure ulcer #1 now measured 6 centimeters by 10 centimeters. It was documented now as a	F 600	stage, location and measurement of wound, notification of MD with new, worsening or wounds that fail to progress with treatment, notification of RR of wound status and that care plan is updated as indicated. On 10/15/20, the DON initiated an in-service with all nurses in regards to Wound Process to include (1) Identifying new skin concerns (2) initiating/completing treatment per physician orders to include documentation on TARs (3) completing wound assessments per facility protocol (4) notification of physician for new or worsening wounds or wounds that fail to progress with treatment (5) Wound Protocols and (6) refusals. In-service will be completed by 11/3/20. All newly hired nurses will be in-serviced by the Human Resource Coordinator (HRC) during orientation in regards to Wound Process. On 10/28/20, the DON initiated an in-service with Medical Director and medical providers in regards to Assessment and Documentation of Wounds during provider visits to ensure the provider is aware of current wounds and is monitoring progress of healing. In-service will be completed by 11/3/20. All newly hired providers will be in-serviced during orientation in regards to Assessment and Documentation of Wounds On 10/29/20, the Human Resource Coordinator initiated an in-service with all nurses and nursing assistants in regards to Neglect to include but not limited to failure to report, assess, monitor and treat	

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F 600	Continued From page 11 suspected deep tissue injury. The wound had moderate amounts of serosanguineous drainage. A wound note dated 8/6/2020 written by the wound care nurse revealed pressure ulcer #1 had 75% deep tissue injury, 25% granulation tissue, and moderate amounts of serosanguineous drainage from the wound. The wound care nurse documented no signs or symptoms of infection to the area. The treatment record for Resident #1 for August 2020 revealed Resident #1 was not documented to have received wound care to the pressure ulcer on her buttocks on 8/1 through 8/3, 8/5, 8/8, and 8/9. She was then discharged on 8/10/20 to the hospital. A nurse practitioner's visit note dated 8/10/2020 revealed Resident #1's nurse practitioner saw Resident #1 on 8/10/2020. She documented staff requested resident be seen for continuing decline with poor meal intake. Resident #1 showed continued evidence of physical and cognitive decline and due to this she was at high risk for developing pressure ulcers and weight loss among other complications. She ordered labs and had all medications held after assessment of the resident. Resident #1 was not awakened and was lying in bed with no distress. The nurse practitioner documented due to the multiple comorbidities and complexities; she was at high risk for complications. A communication note dated 8/10/2020 revealed Resident #1 sustained a change in condition with a blood pressure of 111/60, regular pulse of 92, respiratory rate of 20, temperature of 97.2, weight of 148 pounds, oxygen saturation of 95%, and	F 600	wounds per protocol and/or MD order. In-service will be completed by 11/3/20. All newly hired nurses and nursing assistants by the HRC during orientation in regards to Neglect. Unit Managers, Nurse Supervisor and/or Minimum Data Set Nurse (MDS) will audit ten (10) charts of residents with wounds utilizing the Wound Ulcer Audit Tool weekly x 8 weeks then monthly x 1. This audit is to ensure all wounds have been assessed per facility protocol with documentation in the Wound Ulcer Flowsheet, initiation of treatment per wound protocol or MD orders, care plan updated for all current wounds to include stage, location and interventions, and MD/RR notified of wound status changes/failure to progress with treatment. The Unit Managers, Nurse Supervisor and/or MDS nurse will address all areas of concern identified during the audit to include assessing resident, initiating treatment per MD orders or wound protocol, completing assessments, updating care plan and notification of MD/RR. The DON will review and initial the Wound Ulcer Audit Tool weekly x 8 weeks, then monthly x 1 month to ensure all areas of concern are addressed. Unit Managers, Nurse Supervisor and/or Manager on Duty will audit ten (10) resident TARs daily x 2 weeks, three x a week x 2 weeks, weekly x 4 weeks then monthly x 1 month utilizing the TAR Audit Tool. This audit is to ensure treatments are completed per physician's order with documentation on the TAR. The Unit Manager, Nurse Supervisor, treatment	

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F 600	Continued From page 12 blood sugar of 188. Her level of consciousness was altered. Resident #1 was lethargic and did not respond to tactile stimuli as she previously had. A new order was received to send Resident #1 to the emergency room. The hospital records dated 8/14/2020 revealed Resident #1 was admitted to the hospital on 08/10/20 with a diagnosis of severe sepsis and the unstageable pressure ulcer to the sacrum. She was transitioned to comfort care and passed away 8/13/2020. There were no measurements of the wound. The wound care nurse no longer worked at the facility and was unavailable for interview after multiple attempts to contact her. During an interview on 10/12/2020 at 10:42 AM Nurse #1 stated she remembered Resident #1. She stated the treatment nurse would perform wound treatment for Resident #1 and she would change the dressing as needed if the wound care nurse was not in the facility. She stated she thought she changed the wound dressing once otherwise she would notify the wound care nurse if she was in the facility. She stated when she cared for Resident #1 the wound on her coccyx was about 3 inches by 3 inches of necrotic tissue with red around the edges. She stated she did not inform the physician of the wounds or measure it as that was the responsibility of the treatment team. She concluded she did not remember discharging Resident #1 but must have been the nurse to discharge the resident since she documented it. During an interview on 10/12/2020 at 11:13 AM Nurse #2 stated she remembered Resident #1.	F 600	nurse and assign hall nurse will address all areas of concern identified during the audit to include assessment of the resident, notification of MD of treatment omission for further instructions and education of the nurse. The DON will review the TAR Audit Tool daily x 2 weeks, three x a week x 2 weeks, weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed. DON will forward the Wound Ulcer Audit Tool, Wound Rounds, weekly wound meeting minutes and TAR Audit Tools to the Executive Quality Assurance Performance Improve Committee (QAPI) monthly x 3 months. The Executive QAPI Committee will review Wound Ulcer Audit Tool, Wound Rounds, weekly wound meeting minutes and TAR Audit Tools monthly x 3 months for 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.	

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She further stated she worked with Resident #1 regularly. She stated she was out for three weeks and when she came back on 8/10/2020 to the facility she asked Nurse #1 why Resident #1 was not behaving normally. She stated Resident #1 did not appear as she had prior to her leaving for three weeks. She stated she did not see the wound and how it had progressed, but she shared her concern with Nurse #1 who then got an order to send Resident #1 to the hospital.

During an interview on 10/13/2020 at 11:38 AM Nurse Aide #2 stated she was very familiar with Resident #1 and was her regular nurse aide. She further stated she remembered many times in June and July of 2020 she would notice the dressing to Resident #1's buttock was soiled or not changed. She stated she would let the nurse know of the concern and it usually took one or two days of reminding the nurses the wound dressing to her buttock needed to be changed before they would change it. She stated she knew the dressings were old because the dates written on the dressing would be a couple days old or the soiled dressing remained soiled in the same way as when she first identified it was soiled two days prior. She stated eventually the nurse would get the wound care nurse to change the dressing and then it would happen again. She stated the wound smelled a little 'raw' and she reported this odor to the nurse as well. She stated she would report these concerns and the nurses would call the wound care nurse and then inform the nurse aide the wound care nurse was busy. She again stated it would usually take more than a day to get the wound care nurse to perform the dressing change.

During an interview on 10/13/2020 at 10:03 AM

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Nurse Practitioner #1 stated she was Resident #1's primary nurse practitioner stated unless the treatment nurse informed her wounds for a resident were getting worse and needed a new order, she did not visualize the wounds. The nurse practitioner stated she did not think she visualized Resident #1's wound as the wound care nurse did not share any concerns about the wound deterioration with her. She stated the wound care nurse did not mention any concerns about the wound to Resident #1's buttock. She further stated she was not notified by the wound care or other nurses of this change in wound size. She stated with a change in the wound status from 6/24/2020 to 7/30/2020 it would have been helpful to be informed. She stated she was not informed by any staff of the change in size to Resident #1's pressure ulcer to her buttock. She concluded she did not remember the wound deterioration ever being brought to her attention. She stated with Resident #1's deterioration the main concern was Resident #1 was not eating well and not allowing herself to be turned and repositioned. It was a steady and continued decline in her status which resulted in her not eating, dehydration which lead to urinary tract infections and her advanced dementia. She stated the main concern with not being notified of this change in the wound is the wound care nurse did not realize or convey the need to change the wound care order in order to treat the pressure ulcer effectively. She concluded there appeared to be concerns with the wound care for Resident #1 after reviewing the measurements, however given her comorbidities and complexity with her deterioration prior to the development of the pressure ulcers, her outcome would not have changed with appropriate wound care.

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During an interview on 10/13/2020 at 1:56 PM Physician #1 stated he vaguely remembered the name of Resident #1 but did not remember her baseline condition in detail. He further stated he did not remember if it was ever brought to his attention that Resident #1 had pressure ulcers, but it was possible it was. He stated he did not recall being notified of any deterioration to the wound. He stated he did not recall visualizing the wound. He stated the nurses had a scope of practice and they had a protocol to follow. Resident #1 was clearly declining, and the outcome would not have change with wound care, therefore he did not feel it was critical the wound care nurse notified him about the deterioration of the wound. He stated with wounds it was always good to inform the nurse practitioner or physician of changes, however he did not believe it to be critical to inform in all cases including this resident who was declining. He concluded wound care should be performed as ordered.

During an interview on 10/13/2020 at 2:26 PM the Director of Nursing stated they could not find the July 2020 treatment record for Resident #1. She further stated due to the missing treatment record for July as well as the missing documentation of treatments in June and August 2020 she could not say if Resident #1 received wound care or not as ordered by the physician. She further stated the wound care nurse should have been providing wound treatments per orders. She stated the treatment nurse should have notified the nurse practitioner or physician of the change in the wound condition. She stated the wound care nurse documented that she had notified the medical doctor and was unsure why it appeared the information did not reach the physician and

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F 600	Continued From page 16 nurse practitioner. The Director of Nursing stated as the orders were never changed, and both the physician and nurse practitioner did not indicate they were aware of the change in the wound it did not appear they were notified. She stated any change in condition should trigger the nurse to notify the physician or nurse practitioner including wound changes even if the resident was declining overall. She stated when she came to the facility July 13th, a plan of correction had already been put in place and she was informed there were wound concerns at the facility. She stated the assistant director of nursing was working with the wound care nurse because the wound care nurse clearly had issue with measure wound accurately as well as what wound dressing products should be used. The Director of Nursing stated she had a wound care nurse from a sister facility come and spend a day with the wound care nurse in the facility to go over every patient with her. The Director of Nursing stated this was done on 8/21/2020. She stated she then initiated meeting with the wound care nurse weekly to go over all residents and rounded with the wound care nurses to observe their technique. She stated the plan of correction completion date was 10/18/2020. The facility had identified the wound care nurse was not recognizing when to request wound care order changes, request wound center appointments, or knowledgeable of the products available for wound care. She concluded the assistant director of nursing and the wound care nurse no longer worked for the facility; however, the plan of correction had not been completed as of this date.	F 600		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		11/3/20

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F 641	Continued From page 17 §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 review and staff interviews the facility failed to accurately code the presence of pressure ulcers on a Minimum Data Set (MDS) assessment for 1 of 2 residents reviewed for pressure ulcers. (Resident #1) Findings included: Resident #1 was admitted to the facility on 7/13/19. Resident #1's active diagnosis included anemia, atrial fibrillation, hypertension, diabetes mellitus, Alzheimer's disease, cerebrovascular accident, and dementia. Review of a wound care note dated 6/11/2020 revealed two stage 2 pressure ulcers were found on Resident #1's left buttock. Treatment was implemented and the responsible party was notified. Resident #1's wound assessment dated 6/24/2020, completed by the wound care nurse, revealed a stage 2 pressure ulcer which measured 1.2 centimeters by 0.2 centimeters. It had scant amounts of serosanguineous drainage, dry red granular tissue on wound bed, and the area around the wound was emaciated. A review of Resident #1's quarterly minimum data set assessment dated 7/1/2020 revealed she was assessed as severely cognitively impaired. She was assessed to have no pressure ulcers at that time.	F 641	F641 Accuracy of Assessments CFR(s): 483.20(g) On 10/14/20, The Minimum Data Set Coordinator (MDS) completed a significant correction to prior comprehensive assessment for Resident # 1 to reflect accurate coding of the presence of pressure wounds by the MDS nurses. Resident # 1 is no longer in the facility. On 10/12/20, 100% audit of section “M” for all residents most current MDS assessment, to include resident #1 was initiated by the Director of Nursing (DON), to ensure all MDS assessments completed are coded accurately to include presence pressure wounds. The MDS completed modifications for all concerns identified during the audit. Audit was completed on 10/14/20. On 10/14/20, a 100% in-service was completed by the Facility Consultant with the MDS Coordinator in regards to on MDS Assessments and Coding per the Resident Assessment Instrument (RAI) Manual with emphasis on completing assessment accurately and completely. All newly hired MDS Coordinator and/or MDS nurse will be in-serviced by the Director of Nursing during orientation in regards to MDS Assessments and Coding. 10% audit of all resident’s most recent MDS assessments section “M” will be	

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F 641	Continued From page 18 During an interview on 10/13/2020 at 11:38 AM Nurse Aide #1 stated she was very familiar with Resident #1 and was her regular nurse aide. Nurse Aide #1 confirmed Resident #1 had a (pressure ulcer or a dressing covering a wound) on her buttocks in June and July of 2020. During an interview on 10/12/2020 at 4:14 PM Minimum Data Set (MDS) Nurse #1 stated the wound care nurse notifies the MDS nurses of any wounds. The MDS nurses review the next required MDS and ensure the wound is captured on the assessment. She further stated Resident #1's MDS dated 7/1/2020 was incorrect and Resident #1 should have been coded for the presents of pressure ulcers. She concluded the wound care nurse should have notified her so she could accurately capture the presences of the wounds on the MDS and she did not do this. The wound care nurse no longer worked at the facility and was unavailable for interview after multiple attempts to contact her. During an interview on 10/12/2020 at 4:45 PM the Administrator stated the wounds should have been captured on Resident #1's minimum data set assessment dated 7/1/2020 and it was not.	F 641	completed by the Director of Nursing utilizing the MDS Accuracy Tool weekly x 8 weeks then monthly x 1 month. This audit is to ensure accurate and complete coding of the MDS assessment to include section “M”. The MDS Coordinator will address all areas of concern identified during the audit to include retraining of the MDS nurse and completing necessary assessment of the resident. The Administrator will review and initial the MDS Accuracy Tool weekly x 8 weeks then monthly x 1 month to ensure any areas of concerns were addressed The DON will forward the results of MDS Accuracy Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months. The Executive QAPI Committee will meet monthly x 3 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.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §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	F 656		11/3/20

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F 656	Continued From page 19 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (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). (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. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (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. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to care plan the presence of pressure ulcers for 1 of 2 residents reviewed for pressure ulcers. (Resident #1)	F 656	F656 Develop/Implement Comprehensive Care Plan CFR(s):483.21(b)(1) Resident #1 no longer resides at the facility.	

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F 656	Continued From page 20 Findings included: Resident #1 was admitted to the facility on 7/13/19. Resident #1's active diagnosis included anemia, atrial fibrillation, hypertension, diabetes mellitus, and Alzheimer's disease. Review of a wound care note dated 6/11/2020 revealed two stage 2 pressure ulcers were found on Resident #1's left buttock. Treatment was implemented and the responsible party was notified. A wound assessment dated 6/24/2020, completed by the wound care nurse, revealed pressure ulcer #1 measured 1.2 centimeters by 0.2 centimeters and was a stage II pressure ulcer. It had scant amounts of serosanguineous drainage, dry red granular tissue on wound bed, and the area around the wound was emaciated. The wound assessments and nursing notes revealed there were no wound care measurements or notes for the pressure ulcer to her buttock from 6/24/2020 through 7/30/2020. A review of Resident #1's care plan dated 7/20/2020 revealed she was not care planned for the presence of pressure ulcers. A wound assessment dated 7/30/2020, completed by the wound care nurse, revealed pressure ulcer #1 now measured 6 centimeters by 10 centimeters. It was documented now as a suspected deep tissue injury. The wound had moderate amounts of serosanguineous drainage. The wound care nurse no longer worked at the	F 656	On 10/12/20, the Director of Nursing initiated an audit of resident with pressure wounds to ensure all wounds were care planned to include location, stage of wound and interventions. The Unit Managers and treatment nurse will address all areas of concern identified during the audit to include updating resident care plan. Audit will be completed by 11/3/20. On 10/14/20, an 100% in-service with return demonstration was initiated by the Minimum Data Set (MDS) Coordinator with all nurses in regards Care Plan Revision with emphasis on initiating and revising care plans to reflect the most current resident plan of care to include but not limited to wounds. In-service will be completed by 11/3/20. All newly hired nurses will be in-serviced by the MDS Coordinator during orientation in regards to Care Plan Revision. The Unit Manager, MDS nurse and Nurse Supervisor will review care plans for ten (10) residents with wounds weekly x 8 weeks then monthly x 1 month utilizing the Wound Audit Tool. This audit is to ensure resident care plans are updated with changes in resident care in regards to the presence of pressure wounds. The Unit Managers and treatment nurse will address all areas of concern identified during the audit to include updating the care plan as indicated and re-training of staff. The DON will review the Wound Audit Tool weekly x 8 weeks then monthly x 1 month to ensure all areas of concern were addressed. The DON will present the findings of the	

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	345237	A. BUILDING _____ B. WING _____	C 10/26/2020

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F 656	Continued From page 21 facility and was unavailable for interview after multiple attempts to contact her During an interview on 10/12/2020 at 4:14 PM MDS Nurse #1 stated the wound care nurse initiated care plans for newly identified pressure ulcers and notified the Minimum Data Set (MDS) nurses. When the MDS nurses reviewed the next required MDS assessment they ensured the wound was captured on the care plan. The MDS nurse stated pressure ulcers should be care planned and concluded Resident #1's wounds should have been captured on the care plan and they were not. During an interview on 10/12/2020 at 4:45 PM the Administrator stated the pressure ulcers should have been captured on the care plan and they were not.	F 656	Wound Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. The Executive QAPI Committee will meet monthly for 3 months and review the Wound 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.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		11/3/20

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F 880	Continued From page 22	F 880		

and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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F 880	Continued From page 23 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review a staff member failed to wear a mask that covered their nose and mouth during resident care for 2 of 3 residents reviewed for infection control (Resident #2 and Resident #3). This failure occured doing a COVID-19 pandemic. Findings included: Review of the Centers for Disease Control and Prevention (CDC) guidance for mask use dated 6/2/2020 revealed masks were not to be worn under the nose or mouth. Review of the facility's in-service for donning and doffing personal protective equipment (PPE) dated 8/21/2020 reveled staff was educated on the use of masks. Nurse Aide #1 received this education on 8/26/2020. During observation on 10/12/2020 at 11:01 AM Nurse Aide #1 was observed in Resident #2's room (on a general population hallway) assisting Resident #2 by wiping his face with a wet cloth. Nurse Aide #1 had her mask under her nose leaving her nose uncovered while assisting the resident. She was approximately 2 feet from the	F 880	F880 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) On 10/14/20, a 100% audit was completed by the Unit Managers of all staff currently working to ensure proper use of masks with emphasis on not pulling mask below nose/mouth when speaking to or in close contact of residents and/or staff. The unit manager addressed all areas of concern identified during the audit. On 10/14/20, a 100% in-service was initiated by the Human Resource Coordinator (HRC) with all staff to include nursing assistant (NA) #1 in regards to Mask Use with emphasis on proper mask placement on employee face and not pulling mask below nose/mouth when speaking to or in close contact of residents and/or staff. In-services will be completed by 11/3/20. All newly hired staff will be in-serviced by the HRC during orientation in regards to Mask Use and PPE Use on Quarantine Unit. Fifteen (15) staff to include staff on all shifts and NA #1 will be monitored by the scheduler utilizing a Mask Audit Tool weekly x 8 weeks then monthly x 1 month	

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F 880	Continued From page 24 resident. During observation on 10/12/2020 at 11:44 AM Nurse Aide #1 was observed assisting Resident #3 to a seat in the dining area. Nurse Aide #1 was guiding the resident with her hands approximately two feet apart. Her mask was observed to be under her nose leaving her nose uncovered. The resident then sat in Nurse Aide #1's lap and Nurse Aide #1 redirected the resident to sit in the chair next to her. As she spoke to the resident, she pulled her mask down and away from her nose and mouth while redirecting the resident. During an interview on 10/12/2020 at 11:45 AM Nurse Aide #1 stated the masks made it difficult to communicate. Nurse Aide #1 then pulled her mask down and away from her nose and mouth and stated she could not understand the conversation. Nurse Aide #1 was approximately 3 feet away from the surveyor. She then replaced her mask and stated she was to have her mask on to cover her nose in the facility. She concluded she did not know why she had pulled her mask away from her nose and mouth while caring for Resident #3 or why she did not have her mask covering her nose while within six feet of Resident #2. During an interview on 10/13/2020 at 9:12 AM the Infection Control Nurse stated staff must wear their mask to cover their nose while within six feet of others in the facility and not pull their mask away from their face during care to speak. She stated this was included in the education Nurse Aide #1 received on 8/26/2020. She concluded Nurse Aide #1 should not have left her nose uncovered by the mask or pulled her mask away from her face to speak while within 6 feet of	F 880	to ensure (1) staff maintain proper mask placement on face, and (2) staff are not pulling mask below nose/mouth when speaking to or in close contact of residents and/or other staff. The Unit Managers and HRC will address all areas of concern identified during the audit to include re-education of staff. The Director of Nursing (DON) will review and initial the Mask Audit Tool weekly x 8 weeks then monthly x 1 month to ensure all areas of concerns were addressed. The DON will forward the results of the Mask Audit to the Executive Quality Assurance (QA) committee monthly for 1 month. The Executive QA Committee will meet monthly for 3 months and review the Mask Audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 880	Continued From page 25 another person. During an interview on 10/13/2020 at 2:26 PM the Director of Nursing stated staff were to ensure their mask covered their nose and not pull the mask down to speak when within 6 feet of others.	F 880		