STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 03/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 000	INITIAL COMMENTS The survey team entered the facility on 02/17/2021 to conduct an unannounced complaint investigation survey. Additional information was obtained offsite from 02/18/2021 through 03/09/2021 therefore, the exit date was 03/09/2021. Event ID#RTPM11. Eight of 42 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and family interviews the facility failed to maintain dependent resident's fingernails trimmed for 2 of 5 residents reviewed for activities of daily living care (Resident #1 & Resident #2). Findings included: 1. Resident #1 was admitted to the facility on 6/2/21. A review of Resident #1's minimum data set assessment dated 12/1/20 revealed he was assessed as severely cognitively impaired. He was assessed to have no behaviors and required extensive assistance with bed mobility, dressing, eating, and personal hygiene. He was totally dependent on staff for transfers, walking in room and corridor, locomotion on and off unit, and toilet	F 677	Springbrook Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Springbrook Nursing and Rehabilitation Center□s 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, Springbrook Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of	4/5/21

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

Electronically Signed | 03/20/2021

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F 677	Continued From page 1 use. His active diagnoses included progressive neurological conditions, coronary artery disease, hypertension, dementia and Parkinson's disease. A review of Resident #1's care plan dated 12/10/2020 revealed he was care planned for Activities of Daily Living and Personal Care. The interventions included to provide physical assistance of staff, set up utensils and grooming supplies needed for grooming within easy reach with physical assistance of staff to complete tasks, physical assistance of staff, and provide 1 on 1 total assistance with meals. During observation on 2/17/21 at 9:32 AM Resident #1's fingernails were noted to be untrimmed and long. All ten fingernails extended approximately ¼ of an inch from the finger. During an interview on 2/17/21 at 12:21 PM Resident #1's family member stated she had voiced concerns to the facility about Resident #1's nails and that they were often long, however she had not seen any change in care. During an interview on 2/17/21 at 10:02 AM Hospice Nurse Aide #1 stated she was unable to trim nails at this facility however she felt Resident #1's nails were extremely long. She concluded she had not brought this to the attention of the staff. During an interview on 2/17/21 at 10:09 AM Nurse Aide #1 stated she took care of Resident #1 many times including on 2/16/21 and he did not refuse any care. She further stated she did not notice his nails were long and did not speak to any other staff about his nails. She concluded her background was as a hospital nurse aide and	F 677	Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F677 ADL Care Provided for Dependent Residents CFR(s):483.24(a)(2) On 2/17/21, the Unit Manager provided nail care to resident #1 and resident # 2. On 2/17/21, the assigned hall nurses completed a 100 % audit of all residents to include resident #1 and resident #2 fingernails and toenails using a resident census. The unit manager, Director of Nursing (DON), and treatment nurse provided oversight to ensure all identified areas of concern addressed. On 2/17/21, the Interim Director of Nursing initiated an in-service with all nurses and nursing assistants to include nursing assistant #1 (NA), NA #2 and nurse #1 in regards to Nail Care with emphasis on (1) nurses and nursing assistant s responsibility in providing nail care (2) refusal for nail care and (3) foot care. In-service will be completed by 4/5/21. All newly hired nurses and nursing assistants to include agency staff will receive education during orientation by the Human Resource Officer. The Unit Manager and Treatment nurse will audit 100% of all resident s nails to include feet and hands utilizing the Nail Care Audit Tool weekly x 4 weeks then monthly x 1. This audit is to ensure	

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F 677	Continued From page 2 they did not allow nurse aides to trim nails and she did not know how it was in this facility. During an interview on 2/17/21 at 10:16 AM Nurse Aide #2 stated she was Resident #1's nurse aide that day. She further stated she had cared for Resident #1 a few times in the last weeks and Resident #1 had never refused care. She further stated she had not noticed his fingernails were long. The nurse aide concluded she was not sure if nurse aides could clip nails. During an interview on 2/17/21 at 10:20 AM Nurse #1 stated she was familiar with Resident #1 and was his regular nurse. She further stated she believed podiatry came to the facility to clip fingernails and usually the Activities Director provides them with a list of who was going to be seen. She stated she did not know where that list came from. She concluded no nurse aide had let her know Resident #1's nails were long, and she had not noticed it herself. During an interview on 2/17/21 at 10:25 AM the Director of Nursing stated fingernails were supposed to be trimmed during activities of daily living care or as assigned if a resident is seen to have long nails. He stated nurse aides were able to clip the fingernails of residents who were not diabetic. He further stated because Resident #1 was not diabetic the nurse aides should have clipped his nails if they were long. Upon observing Resident #1's fingernails with the surveyor he concluded the nails were very long and should have been trimmed a long time ago. 2. Resident #2 was admitted to the facility on 12/23/20 with diagnoses which included diabetes mellitus and non-Alzheimer's dementia.	F 677	resident nails cleaned and trimmed per resident preference. The Unit Manager, Assistant Director of Nursing (ADON) and Treatment nurse will address all areas of concern identified during the audit to include providing resident nail care as indicated and retraining of staff. The DON will review the Nail Care Audit Tools weekly x 4 weeks then monthly x 1 month to ensure all areas of concern addressed. DON will forward the Nail Care Audit Tool results to the Executive Quality Assurance Performance Improvement (QAPI) Committee monthly x 2. The Executive QAPI Committee will review Nail Care Audit tool x 2 months 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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F 677	Continued From page 3	F 677		

Resident #2's quarterly Minimum Data Set dated 1/28/21 indicated he had severe cognitive impairment and required extensive assistance to total dependence on staff for activities of daily living.

The care plan revised 1/28/21 identified that Resident #2 had a focus on activities of daily living and personal care with a goal for staff support as appropriate to maintain function.

An observation on 2/17/21 at 10:43 AM with Nurse #2 at Resident #2's bedside revealed he had very long, thick, discolored toenails on his right foot which curled under his toes. Further observation revealed his fingernails on both hands were approximately ¼ to ½ inches long with ragged edges and black debris under all nails.

An interview on 2/17/21 at 1:02 PM with NA #3 revealed she was responsible for providing fingernail care for Resident #2 and the hall Nurse was responsible for providing toenail care. She stated she had not provided his nail care this morning due to providing another staff member assistance. She stated she did not know when nail care had been provided for him.

An interview on 2/17/21 at 10:43 AM with Nurse #2 revealed she confirmed Resident #2's toenails and fingernails were too long and dirty and he should have received nail care. She stated the Nursing Assistant (NA) or hall Nurse should have provided finger and toe nail care.

An interview on 2/17/21 at 10:51 AM with Nurse #3 revealed she confirmed Resident #2's toenails and fingernails were too long and dirty and he

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F 677	Continued From page 4 should have received nail care. She stated nurses were responsible to ensure the resident had nail care performed. She stated she did not normally work on that unit and she could not say why Resident #2 had not received nail care. An interview and observation on 2/17/21 at 11:15 AM with the Interim Director of Nursing (DON) and the Corporate Nurse Consultant revealed they agreed Resident #2's toenails and fingernails were too long and dirty and he should have received nail care. The DON stated his toenails and fingernails were unacceptable and he did not know why he had not received nail care. An interview on 2/19/21 at 1:41 PM with the Administrator revealed she did not know why Resident #2 had not received nail care but stated the resident should have received nail care.	F 677		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 686		4/5/21

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F 686	Continued From page 5 Based on record reviews, staff interviews, and physician interviews, the facility failed to complete a weekly skin assessment and failed to provide treatment for left shoulder, right and left hip pressure ulcers (Resident #3) for 1 of 2 residents reviewed for pressure ulcers. Finding included: 1. Resident #3 was admitted to the facility on 5/31/20 with diagnoses which included: lewy body dementia, chronic obstructive pulmonary disease, chronic diastolic congestive heart failure, hypertension, hypothyroidism, chronic anemia, history of Clostridium difficile, asthma, acute respiratory failure with hypoxia, unspecified protein calorie malnutrition, dysphagia, and peripheral vascular disease. He was discharged to the hospital on 1/19/21 and he did not return to the facility. Resident #3's most recent Minimum Data Set (MDS) dated 1/1/21 indicated he was severely cognitively impaired and required total dependence on staff for most activities of daily living. The MDS further indicated he had 3 stage 2 pressure ulcers and 1 unstageable pressure ulcer. Resident #3's care plan most recently revised on 1/15/21 revealed a focus on pressure ulcers with goals that current pressure injuries will not develop further or worsen in size and remain free of infection through the next review date. Interventions included to check for incontinence on rounds, off load heels, apply protective barrier cream after incontinence care, observe skin for redness, swelling, tenderness, bruising or open areas and notify nurse for concerns.	F 686	F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) Resident #3 no longer resides in the facility. On 3/9/21, the Unit Manager, hall nurse and treatment nurse initiated a 100% skin check. This audit is to identify any resident with new skin concerns/ wounds to ensure all concerns properly assessed, treatment initiated, MD/RR notified, documentation completed in the Wound Ulcer Flowsheet or Non-Ulcer Flowsheet, incident report completed for any newly identified wounds and care plan updated. All areas of concern will be addressed by the treatment nurse and assigned hall nurse to include assessment of resident, completion of incident report, notification of MD/RR, initiating treatment per MD orders, documentation in Wound Ulcer Flowsheet or Non-Ulcer Flowsheet and updating care plan. Audit completed by 3/15/21. On 3/17/21, the Facility Consultant completed a 100% audit of all TARs 3/1/21-3/16/21 to ensure treatments completed per physician□s order with documentation on the TAR. The Assistant Director of Nursing (ADON), Unit Manager, treatment nurse and/or assigned 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.	

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F 686	Continued From page 6 Resident #3's care plan also revealed a focus which read in part that pressure ulcers identified, and resident is at risk for further impairment in skin related to decreased mobility and functioning. The interventions included to assist with turning and repositioning frequently and as needed. a. Review of the Wound Ulcer Flowsheets revealed right and left hip assessments dated 12/23/20, 1/06/21, and 1/14/21. An interview on 3/08/21 at 11:07 AM with the Nurse #2 revealed she was responsible for completing weekly Wound Ulcer Flowsheets. She stated she was working on a medication cart on 12/30/20 and did not have time to complete Resident #3's weekly Wound Ulcer Flowsheets. An interview on 3/9/21 at 10:39 AM with the Interim Director of Nursing (DON) revealed skin assessments and wound measurements should be completed weekly. An interview on 3/09/21 at 10:54 AM with the Administrator revealed skin assessments and wound measurements should be completed weekly. b. Review of Physician's Orders revealed an order dated 12/17/20 for Resident #3's left hip pressure ulcer dressing for Santyl ointment (a debriding agent) applied every day. This order was discontinued on 12/29/20 and a new order initiated on 12/30/20. Review of Physician's orders revealed an order dated 12/30/20 for Resident #3's left hip pressure	F 686	On 3/3/21 100% In-service was initiated by the Unit Manager with all nurses to include nurse #2, #4 and #5 in regards to (1) Wound Process with emphasis on ensuring accurate treatment orders are received, wound treatment protocols, weekly completion of wound assessments, staging wounds, notification of MD/RR and updating care plans and (2) TAR Documentation. In-services will be completed by 4/5/21. All newly hired nurses to include agency staff will complete in-services during orientation by the Human Resource Officer. The Assistant Director of Nursing (ADON) will complete an audit on 10% of residents with wounds utilizing the Wound Audit Tool weekly x 4 weeks then monthly x 1 month to ensure wounds area assessed weekly per facility protocol with documentation in the electronic record and the physician and resident representative notified of wound status changes. The ADON, Unit Managers and treatment nurse will address all areas of concern identified during the audit to include assessment of the resident if indicated and re-training of staff. 10 Treatment Administration Records (TARs) will be reviewed 3 times a week x 2 weeks, then weekly x 2 weeks, then monthly x 1 month by the ADON, and/or Unit Managers utilizing the TAR Audit Tool to ensure treatments are completed per physician order with documentation on the TAR. The Unit Manager, treatment nurse,	

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F 686	Continued From page 7 ulcer wound to be cleaned with normal saline, patted dry, Santyl ointment (a debriding agent) applied, and covered with dressing every day. Review of the December Treatment Administration Record (TAR) revealed the left hip pressure ulcer wound dressing was not signed as completed on 12/25/20 and 12/29/20. Review of the January TAR revealed the left hip pressure ulcer wound dressing was not signed as completed on 1/01/21, 1/16/21, and 1/17/21. c. Review of Physician's Orders revealed an order dated 12/17/20 for Resident #3's left shoulder pressure ulcer wound to be cleaned with normal saline, patted dry, silver alginate (antimicrobial) dressing applied, and covered with a foam dressing every 3 days. This order was discontinued on 12/29/20 and a new order initiated on 12/30/20. Review of Physician's Orders revealed an order dated 12/30/20 for Resident #3's left shoulder pressure ulcer wound to be cleaned with normal saline, patted dry, silver alginate (antimicrobial) dressing applied, and covered with a foam dressing every other day. Review of the December Treatment Administration Record (TAR) revealed the left shoulder pressure ulcer wound dressing was not signed as completed on 12/29/20. Review of the January TAR revealed the left shoulder pressure ulcer wound dressing was not signed as completed on 1/01/21 and 1/17/21. d. Review of Physician's Orders revealed an	F 686	and ADON 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 Director of Nursing (DON) will review the Wound Audit Tool and TAR Audit Tool 3 times a week x 2 weeks, then weekly x 2 weeks, then monthly x 1 month to ensure all areas of concern have been addressed. The Administrator will forward the Wound Audit Tools and TAR Audit Tools to the Executive Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The Executive QAPI Committee will review Wound Audit Tools and TAR Audit Tools x 2 months 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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F 686	Continued From page 8	F 686		

order dated 12/17/20 for Resident #3's right hip pressure ulcer wound to be cleaned with normal saline, patted dry, apply silver alginate (antimicrobial) dressing, covered with foam dressing every 3 days. This order was discontinued on 12/29/20 and a new order initiated on 12/30/20.

Review of Physician's Orders revealed an order dated 12/30/20 for Resident #3's right hip pressure ulcer wound to be cleaned with normal saline, patted dry, apply silver alginate (antimicrobial) dressing, covered with foam dressing every other day.

Review of the December Treatment Administration Record (TAR) revealed the right hip pressure ulcer wound dressing was not signed as completed on 12/29/20.

Review of the January TAR revealed the right hip pressure ulcer wound dressing was not signed as completed on 1/01/21 and 1/17/21.

An interview on 3/08.21 at 11:51 AM with Nurse #5 revealed she worked on 1/16/21 and was unaware she was supposed to complete wound care. She further stated she did not even know how to "sign off" on the wound care orders.

An interview on 3/08/21 at 6:36 PM with Nurse #4 revealed she was not aware she was supposed to provide wound care for Resident #3 when she worked on 12/25/20.

An interview on /19/21 at 10:14 AM with the Physician revealed he felt wound care was completed appropriately. He further stated he felt the dressing changes were getting done.

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F 686	Continued From page 9 An interview on 3/9/21 at 10:39 AM with the Interim Director of Nursing (DON) revealed that if treatments are completed the nurse should sign as completed on the TAR. An interview on 3/09/21 at 10:54 AM with the Administrator revealed if treatments are completed they should be documented on the TAR.	F 686		
F 842 SS=D	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	F 842		4/5/21

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F 842	Continued From page 10	F 842		

representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care 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.

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SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 842	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to maintain accurate medical records for (1) meal intake and (2) wound care orders for 1 of 1 residents reviewed for nutrition (Resident #3). Finding included: 1. Resident #3 was admitted to the facility on 5/31/20 with diagnoses which included malnutrition and congestive heart failure. He was discharged to the hospital on 12/7/20 and returned to the facility on 12/14/20. He was discharged to the hospital again on 1/19/21. Resident #3's most recent Minimum Data Set dated 1/1/21 indicated he was severely cognitively impaired, totally dependence on staff for most activities of daily living and received his nutrition through a feeding tube. Review of Physician's Orders revealed an order dated 12/14/20 for Resident #3 to have nothing per mouth (NPO). Review of the facility form title "Documentation Survey Report" for December 2020 revealed staff documented Resident #3 to have consumed 100% of meals 7 times between 12/14/20 and 12/31/20. Review of the January 2021 Documentation Survey Report revealed staff documented Resident #3 to have consumed 50% - 100% of meals 16 times between January 1 and January 19, 2021.	F 842	F842 Resident Records-Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) Resident #3 no longer resides in the facility. On 3/17/21, the Minimum Data Set (MDS) nurse completed an audit of meal intake documentation for all residents with orders to be “nothing by mouth” (NPO) from 3/1/21-3/17/21 to ensure staff were not providing meal(s) or documenting meal intake for residents who were NPO. There were no additional concerns identified. The Minimum Data Set Nurse removed the icon for meal intake documentation for any resident who does not receive meals or supplements by mouth. On 3/17/21, the Director of Nursing initiated an audit of admission orders to include orders for wound care for all newly admitted or readmitted residents from 3/10/21-3/16/21. This audit is to ensure all admission orders were verified and entered timely into the electronic record. The Unit Manager, Assistant Director of Nursing (ADON) and/or Treatment nurse will address all concerns identified during the audit. Audit will be completed by 4/5/21. On 3/17/21, the Assistant Director of Nursing initiated an in-service with all nursing assistants (NA) to include NA #2, NA #4, and NA #5 in regards to	

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F 842	Continued From page 12 An interview on 2/19/21 at 10:00 AM with Nursing Assistant (NA) #5 revealed she was aware Resident #3 had a feeding tube and did not receive food by mouth. She stated she had documented in error and the documented meal intake was for another resident. An interview on 2/19/21 at 11:07 AM with NA #2 revealed she had never fed Resident #3 and she had documented his meal intake in error. An interview on 2/19/21 at 1:51 PM with NA #4 revealed she was aware Resident #3 was NPO. She stated she had documented his meal intake in error. An interview on 2/18/21 at 2:56 PM with the Interim Director of Nursing revealed he expected the NA's to enter all resident meal intake information correctly. An interview on 2/19/21 at 1:41 PM with the Administrator revealed she was unaware of the meal intake documentation errors for Resident #3. She stated meals should be documented correctly and she did not know why there were documentation errors. 2. Resident #3 was admitted to the facility on 5/31/20 with diagnoses which included malnutrition and congestive heart failure. He was discharged to the hospital on 12/7/20 and returned to the facility on 12/14/20. He was discharged to the hospital again on 1/19/21. Resident #3's most recent Minimum Data Set dated 1/1/21 indicate he was severely cognitively impaired and was totally dependent on staff for most activities of daily living.	F 842	Documentation in Point of Care (POC) with emphasis on completing resident care documentation to include but not limited to meal intake accurately and timely. In-service will be completed by 4/5/21. All newly hired nursing assistants will be in-serviced on Documentation in POC during orientation by the Human Resource Coordinator. On 3/17/21, The Assistant Director of Nursing initiated an in-service with all nurses to include treatment nurse in regards to Transcribing Orders with emphasis on transcribing orders to include wound treatment orders accurately and timely. In-service will be completed by 4/5/21. All newly hired nurses will be in-serviced on Transcribing Orders during orientation by the Human Resource Officer. The MDS nurse will review Meal Intake Documentation for all residents with orders to be “nothing by mouth” (NPO) weekly x 4 weeks, then monthly x 1 month to ensure staff were not providing meal or documenting meal intake for residents who were NPO. The ADON, Unit Managers and/or Minimum Data Set Nurse will address all areas of concern identified during the audit to include re-training of staff. The MDS nurses will review admission orders to include wound orders for all newly admitted or readmitted residents 5 times a week during Cardinal IDT utilizing the Admission Orders Audit Tool to ensure	

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F 842	Continued From page 13 Review of hospital discharge summary dated 12/14/21 read in part a physician's order to change the left hip wound dressing daily with wet to dry dressing and apply Santyl (a debriding agent). Another physician's order read in part to change right hip dressing every 3 days with a silver gauze dressing. Review of physician's orders for December 2020 revealed the above orders for left and right hip wound dressings were transcribed into Resident #3's medical record on 12/17/20. Review of the Treatment Medication Record (TAR) dated December 2020 revealed the left hip wound dressing was first signed as completed on 12/17/20. Review of the TAR dated December 2020 revealed the right hip wound was first signed as completed on 12/17/20. An interview on 2/19/21 at 11:06 AM with the Treatment Nurse revealed she had completed Resident #3's dressing changes on 12/15/20 and 12/16/20. An interview on 2/19/21 at 10:26 AM with the Physician revealed he had seen Resident #3 on 12/16/20 and had removed the left hip wound dressing and felt the left hip wound looked good. He also revealed the dressing was ok and he believed the dressing changes were being done. The Physician stated the wound care orders should have been entered within 48 hours. An interview on 2/18/21 at 2:56 PM with the Interim Director of Nursing revealed he expected	F 842	all admission orders verified and entered timely into the electronic record. The Unit Manager, ADON and/or treatment nurse will address all concerns identified during the audit to include updating orders as indicated and/or re-training of staff. The Director of Nursing (DON) will review the Meal Intake Documentation and Admission Orders Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern have been addressed. The Administrator will forward the Meal Intake Documentation and Admission Orders Audit Tool/Admission Checklist to the Executive Quality Assurance Performance Improvement (QAPI) Committee monthly x 2. The Executive QAPI Committee will review Meal Intake Documentation and Admission Orders Audit Tool/Admission Checklist x 2 months 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. The Administrator and Director of Nursing are responsible for all audits, in-services and monitoring for plans of correction. Final compliance date is: April 5, 2021	

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F 842	Continued From page 14 the physician's orders to transcribed in a timely manner. An interview on 2/19/21 at 1:41 PM with the Administrator revealed she expected wound care orders to be transcribed for residents.	F 842		