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	345534	A. BUILDING _____ B. WING _____	C 03/09/2022

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SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

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F 000	INITIAL COMMENTS The surveyor entered the facility on 3/7/22 to conduct an unannounced complaint investigation and exited on 3/8/22. Additional information was obtained offsite on 3/9/22. Therefore, the exit date was 3/9/22. Two of the seven complaint allegations were substantiated. Event ID# --JUAR11	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 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 observation, record review, resident interview, staff interviews, and Nurse Practitioner interview the facility failed to assure treatment was done for diabetic ulcers. This was for one (Resident # 1) of one sampled resident with diabetic ulcers. The findings included: Resident # 1 was initially admitted to the facility on 1/4/19. Some of Resident # 1's diagnoses included diabetes, peripheral artery disease, and chronic heel ulcer. Resident # 1's minimum data set assessment, dated 2/14/22, coded the resident as cognitively intact and has having a diabetic ulcer.	F 684	This plan of correction constitutes a written allegation of compliance preparation, and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set fourth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirements under state and federal law. F684 Residents #1 dressing was not completed on 3-2-2022. Dressing change completed	3/22/22

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

Electronically Signed | 03/21/2022

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F 684	Continued From page 1 Resident # 1's care plan, revised on 2/15/22, included the problem that Resident # 1 had a diabetic ulcer to his right heel and the top of his right foot. This problem had been added to Resident # 1's care plan on 6/9/21 and remained as an active part of his current care plan. One of the approaches was to administer treatments per order. Resident # 1's care plan also included information that the resident was not compliant with medical care and refused care at times. Review of Resident # 1's diabetic ulcers' measurements revealed they had decreased in size since developing. A narrative note on 2/24/22 included information that both ulcers had 100 % granulation tissue. Current orders for the diabetic ulcers included the following. Staff were to clean the right heel with wound cleanser, pat the wound dry, apply collagen AG (alginate) which was moistened with normal saline to the wound bed, cover with a thick pad, and wrap the dressing with gauze wrap followed by an ace wrap. This was to be done three days per week on Tuesday, Thursdays, and Saturdays. Staff were to clean the diabetic ulcer to the top of his foot with normal saline or wound cleanser, pat the wound dry, apply medihoney and wrap the dressing with a gauze wrap followed by an ace bandage. This was also to be done three days per week on Tuesdays, Thursdays, and Saturdays. Resident # 1's March, 2022 TAR (Treatment Administration Record) included documentation that Nurse # 2 had completed these treatments on 3/5/22 (a Thursday). Nurse # 2 was interviewed on 3/8/22 at 1:10 PM	F 684	on 3-3-2022. MD and RP made aware on 3-3-2022 by wound nurse. 100% audit of all in house residents with diabetic ulcers, over the last two weeks were audited on 3-14-2022 for completion of dressing changes by DON/Unit Manager. Any resident who did not get a dressing change, the MD and RP were notified on 3-14-2022 by DON/Unit Manager. 100% in-service was conducted to all licensed Nurses on 3-14-2022 by DON regarding the importance and necessity of completion of dressing changes for diabetic ulcers. Any licensed nurse who did not receive the in-service by 3-21-22 is not allowed to work until the in-service has been completed. The education will be added to the orientation of all nurses. The DON or designee will audit all diabetic ulcer dressing changes for completion daily x 2 weeks, then twice a week x 4 weeks then weekly x 4 weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing or designee monthly for 3 months. At that time, the QAPI committee will evaluate the effectiveness of the intervention to determine if continued auditing is necessary to maintain compliance.	

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F 684	Continued From page 2 and reported the following. She had worked on 3/3/22 (Thursday) when Resident # 1's diabetic ulcer dressings were to be changed. She did not do them. According to Nurse # 2, Nurse # 5 (the wound care nurse) had been called in to work on the night shift which began on 3/2/22. The nurses use a phone app to communicate and it was Nurse # 2's understanding from reviewing information in the phone app that Nurse # 5 changed Resident # 1's dressings before Nurse # 5 left work. According to Nurse # 2, she went ahead and signed the dressings were done on the TAR because it was her understanding they had been done by Nurse # 5 for the date of 3/3/22. During an interview on 3/8/22 at 4:15 PM with Nurse # 5, she stated that she had been called in to work the night shift of 3/2/22 on a hall other than the one on which Resident # 1 resided. Before she left work on the morning of 3/3/22, she had done treatments on that hall only, but no other hall in the facility. Nurse # 5 stated she had not changed Resident # 1's dressings on 3/3/22 before she left as Nurse # 2 had thought she had. The Nurse Practitioner, who routinely cares for Resident # 1, was interviewed on 3/9/22 at 2:00 PM and reported the following. It would be her expectation that the nurses apply dressings per orders. The NP also stated she did not think the lack of application had contributed to a negative outcome for Resident # 1. She was aware the resident was not compliant with medical care at times and smoked. She stated these things contributed to his wounds not healing.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		3/22/22

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F 686	Continued From page 3 §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: Based on observation, record review, resident interview, staff interviews, and Nurse Practitioner interview the facility failed to assure pressure sore treatment was done per order and the functioning of a wound vac was monitored. This was for one (Resident # 1) of two sampled residents with a pressure sore. The findings included: Resident # 1 was initially admitted to the facility on 1/4/19. The resident had diagnoses of Parkinson's disease with Lewy body dementia, diabetes, peripheral artery disease, chronic sacral decubitus ulcer, chronic heel ulcer, major depressive disorder, and anxiety disorder. The resident's minimum data set assessment, dated 2/14/22, coded the resident as cognitively intact and has having a Stage 4 pressure sore. The resident's care plan, last reviewed on 2/15/22, identified Resident # 1 to have a	F 686	F686 Resident #1 wound vac was changed was changed on 3-3-22 by wound nurse. MD was notified of incomplete dressing change on 3-3-2022 by wound nurse. Resident made aware on 3-3-2022 100% Audit of all in house residents with pressure sore treatment including the use of a wound vac was completed on 3-14-2022 by DON/Unit Manager for completion of treatment and functioning of wound vac. 100% in-service to all licensed nurses was initiated on 3-14-2022 by DON and completed on 3-18-2022. Any licensed nurse who did not receive the in-service will not be allowed to work until the in-service has been completed. The education will be included in the new hire	

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F 686	Continued From page 4 pressure sore to his sacrum/left buttock area. This problem had been added to the care plan on 10/6/21 and remained as a current problem. Some of the Interventions included to apply a wound vac to the resident's sacrum/left buttock wound, administer treatments as ordered, and document the treatments. The care plan also included information that the resident refused care and was non-compliant with medical care. According to facility wound records, the pressure sore first developed on 10/5/21 to the buttock area and measured 7 cm X 3 cm X .2 cm (centimeters). Resident # 1 was hospitalized on 11/2/21 and returned on 11/12/21. Upon readmission, the resident had a sacral pressure sore that had merged with the buttock pressure sore; in total measuring 8.6 cm X 4.7 cm X 5 cm with undermining at 8:00 o'clock to the extent of 4.6 cm. (Undermining is when the tissue under the wound edges becomes eroded resulting in a pocket beneath the edge of the wound.) Most recent Sacral pressure sore measurements, dated 3/1/22, showed the sacral pressure sore to be 1.9 cm X 1.4 cm. X 2 cm with undermining of 4 cm. Resident # 1's sacrum pressure sore order, dated 3/1/21, was for the following. Staff were to cleanse the pressure sore, pat it dry, apply skin prep to the periwound, moisten collagen AG (alginate) with normal saline and apply it to the wound bed. (This helps with absorption of any drainage). Then they were to apply a wound vac at 150 mmHG continuous pressure. This was to be done on Tuesdays, Thursdays, and Saturdays. Review of Resident # 1's TAR March, 2022	F 686	orientation process. The Director of Nurses or designee will audit all pressure sore treatments and wound vac functioning daily x 2 weeks, then twice a week x 2 weeks then weekly x 4 weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing designee monthly for three months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continue auditing is necessary to maintain compliance.	

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F 686	Continued From page 5	F 686		

(treatment administration record) revealed Nurse # 2 signed she administered this treatment and wound vac on Thursday 3/3/22. Nurse # 3 signed that she administered this treatment and wound vac on Saturday 3/5/22.

Resident # 1 also had a PRN (as needed) order, dated 1/3/22 and discontinued on 3/7/22, to clean the buttock pressure sore and apply a wet to dry dressing daily as needed for soilage or removal. This PRN order was not signed off on any dates from 3/1/22 to 3/6/22.

On 3/7/22 (Monday) Resident # 1 was observed in his room. The wound vac was in the floor and not connected. Resident # 1 stated he had been having problems getting the nurses to apply the wound vac to his pressure sore as ordered and change the dressing; they were to apply it on Thursdays and Saturdays with dressing changes. He then went to a wound clinic on Tuesdays and the physician evaluated and replaced it on that date.

Nurse # 5, who was the facility wound care nurse, was interviewed on 3/8/22 at 10:30 AM and reported the following. The wound vac did not stay on well because the resident was noncompliant with getting help when he had soiled himself and stool would then cause the seal to break. Prior to 3/1/22, he had orders to try an alternative dressing, but the wound vac and collagen AG were restarted on 3/1/22 by a verbal order. She applied this dressing and wound vac on 3/1/22. She then did not work as the wound nurse for the rest of the week and therefore she did not know what had happened or why the wound vac was not in place on 3/7/22.

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F 686	Continued From page 6	F 686		

Nurse # 2 was interviewed on 3/8/22 at 1:10 PM and reported the following. She had worked on 3/3/22 (Thursday) when Resident # 1's Sacral dressing was due to be changed and the wound vac reapplied. She did not do it. According to Nurse # 2, Nurse # 5 had been called in to work on the night shift which began on 3/2/22. The nurses use a phone app to communicate and it was Nurse # 2's understanding from reviewing information in the phone app that Nurse # 5 changed Resident # 1's dressing and reapplied the wound vac that AM before Nurse # 5 left work. According to Nurse # 2, she went ahead and signed it was done on the TAR because it was her understanding the treatment/wound vac had been done by Nurse # 5.

During a follow up interview on 3/8/22 at 4:15 PM with Nurse # 5, she stated that she had been called in to work the night shift of 3/2/22 on a hall other than the one on which Resident # 1 resided. Before she left she had done treatments on that hall only, but no other hall in the facility, and she had not changed Resident # 1's dressing or applied the wound vac on 3/3/22.

Nurse # 4 was interviewed on 3/8/22 at 5:05 PM and reported the following. She had worked on Saturday, 3/5/22, when the dressing was to be changed and the wound vac reapplied. Her shift was from 7 AM to 7 PM. When she arrived that morning, the wound vac was off and she did not know why. She offered to do the dressing and wound vac, but the resident went out to smoke and was gone outside all day. He did not come to her until 6:55 PM and at that time told her to just put on a wet to dry dressing. That is what she did. On Sunday, 3/6/22, the dressing did not flag on the TAR to be changed, and Resident # 1 was not

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F 686	Continued From page 7	F 686		

available. Therefore, she did not apply a dressing or attempt to reapply the wound vac.

Nurse # 3, who had signed that the wound vac was applied on Saturday, 3/5/22, was interviewed on 3/7/22 and reported the following. She had assisted Nurse # 4 with dressings on 3/5/22 for Resident # 1 but did not know anything about the wound vac or why it had not been on.

On 3/9/22 at 1:20 PM the Administrator, Nurse # 5 (the wound nurse), and the unit manager were interviewed via phone. They reported the following. They had tried to find out what had happened between Thursday, 3/3/22 and Saturday, 3/5/22 but none of the staff could recall or tell them how the wound vac came off or what efforts had been taken to replace it prior to the morning of 3/5/22 when it was observed off by Nurse # 4. According to Nurse # 5, the facility had previously put on the TAR for nurses to check the functioning of the wound vac every 12 hour shift as a nursing measure to assure it was functioning. When the orders were reinitiated on 3/1/22 for the use of the wound vac, this had not been added to the TAR to alert nursing staff that they needed to be checking to assure the wound vac was on and functioning.

The Nurse Practitioner, who routinely cares for Resident # 1, was interviewed on 3/9/22 at 2:00 PM and reported the following. It would be her expectation that the nurses would be checking on the wound vac to assure it is in place and applying it per orders. The NP also stated she did not think the lack of application had contributed to a negative outcome for Resident # 1's pressure sore. She was aware the wound vac did not seal for long periods of time due to the resident's

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F 686	Continued From page 8 behavior of not calling for assistance with incontinence care timely. The NP stated such things as smoking, refusal of care and medications contributed to the lack of healing of Resident # 1's pressure sore.	F 686		