STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345293	A. BUILDING _____ B. WING _____	C 05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345

(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
E 000	Initial Comments An unanounced recertification survey was conducted 5/9/22 through 5/12/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# J4MM11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 5/9/22 to 5/12/22. Event ID # J4MM11. 2 of the 7 complaint allegations were substantiated resulting in deficiencies. NC00185587, NC00187867, NC00188534, NC00188719 The Statement of Deficiencies was amended on 5/31/22 at tag F677.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		6/9/22

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

Electronically Signed | 06/02/2022

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to promote dignity by not providing a privacy cover over a urinary drainage bag for 1 of 1 residents reviewed for dignity (Resident #34). The findings included: Resident #34 was admitted to the facility on 9/28/21 with diagnosis that included retention of urine. Review of a quarterly Minimum Data Set (MDS)	F 550	Richmond Pines 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 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. Richmond Pines Nursing and Rehabilitation Center s response to this Statement of Deficiencies does not	

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F 550	Continued From page 2 assessment dated 3/1/22 indicated Resident #34 was cognitively intact. He required extensive assistance from staff for toileting needs and had an indwelling urinary catheter. During an interview and observation with Resident #34, on 5/9/22 at 10:22 AM, he was noted to have an indwelling urinary catheter with the drainage bag attached to the right side of the bed. The drainage bag did not have a privacy cover, had dark yellow urine in the drainage bag and could be seen from the hallway. Resident #34 stated he knew the bag was visible from the hallway and to others and would prefer for it to be covered. On 5/9/22 at 1:15 PM, an observation was made of Resident #34 with the urinary drainage bag attached to the right side of the bed. The drainage bag did not have a privacy cover, had yellow urine in the bag, and could be seen from the hallway. An observation occurred of Resident #34 while he was lying in bed on 5/10/22 at 11:09 AM. The urinary drainage bag was clipped to the right side of the bed, without a privacy cover, and visible from the hallway with dark yellow urine in the drainage bag. On 5/11/22 at 10:28 AM, Resident #34 was observed while lying in bed. The urinary drainage bag with dark yellow urine, remained without a privacy cover and was visible from the doorway. An interview occurred with Nurse #1 on 5/11/22 at 10:35 AM and stated all residents with urinary catheters should have a privacy cover on the drainage bags. She stated Resident #34 had	F 550	denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Richmond Pines Nursing and Rehabilitation Center 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 proceedings On 5/9/22, during a recertification and complaint survey at Richmond Pines Healthcare and Rehabilitation Center, the survey team observed Resident #34 did not have privacy/dignity bag on his urinary drainage bag. Resident #34 continues to reside at the facility and continues to require the use of a urinary drainage bag. On 5/29/22, Resident #34 was asked by nursing staff if he would like a privacy/dignity bag for urinary drainage bag. Resident #34 stated he would like a dignity/privacy bag. Nursing staff applied a dignity/privacy bag to Resident #34 urinary drainage bag. This task will continue as Resident #34 allows. Root Cause: Resident #34 had stated upon admission, he did not want a dignity/privacy bag on his urinary drainage bag so he could observe his urine color. Nursing staff did not document, or care plan this preference. Nursing staff did not revisit Resident #34 regarding a dignity/privacy bag on his urinary drainage bag.	

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F 550	Continued From page 3 recently been to the Emergency Room and could be the reason why he didn't have a privacy cover on the drainage bag. Nurse #1 indicated she would make sure one was provided for Resident #34. During an interview with the Administrator and Director of Nursing on 5/12/22 at 1:14 PM, they both indicated it was their expectation for nursing staff to use a privacy cover for urinary drainage bags and was unable to state why Resident #34's drainage bag was not covered.	F 550	All residents who have a catheter/urinary drainage bag have the potential to be affected by this alleged deficient practice. To correct the deficient practice, these residents will be included in the prescribed audits to ensure their rights, preferences and care plans reflect the corrective practice. On 5/17/22 through 5/20/22 the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) and assigned special project department head began & completed 100% audit of residents with urinary drainage bag being covered for dignity with a dignity/privacy bag. Any resident requesting not to have a privacy/dignity bag for urinary drainage bag was documented and care planned to reflect this preference. The Staff Development Coordinator (SDC), Director of Nursing (DON), Assistant Director of Nursing (ADON), and Regional Clinical Nurse Consultant will begin education on 6/1/22 on ensuring urinary drainage bag being covered for dignity with a dignity/privacy bag. This education will be completed on 6/8/22. On 6/1/22, the SDC added this education to the new hire packet and agency/contract staff packet. On 6/9/22, the Staff Development Coordinator will mail education to any Contracted Agency/Facility Nursing Staff that had not completed education of ensuring resident urinary drainage bag	

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F 550	Continued From page 4	F 550	being covered for dignity with a dignity/privacy bag. After 6/8/22, no Contracted Agency/Facility Nursing Staff will be allowed to work until education on ensuring resident urinary drainage bag being covered for dignity with a dignity/privacy bag. Beginning 6/9/22, the Director of Nursing, Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) and assigned special project department head will complete monitoring to ensure compliance of ensuring resident rights/exercise rights: urinary drainage bag being covered for dignity with a dignity/privacy bag. The Director of Nursing, the Unit Manager(s), and/or the assigned special project department head will observe six random residents 5x/week x 4 weeks, then 3x/week x 4 weeks, then 2x/week x 4 weeks to ensure compliance that resident rights/exercise rights: urinary drainage bag being covered for dignity with a dignity/privacy bag Beginning 6/15/22 the Director of Nursing, Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) and/or assigned special project department head will report the findings of the monitoring that resident rights/exercise rights: urinary drainage bag being covered for dignity with a dignity/privacy bag to the members of the Cardinal Intradisciplinary Team once weekly x3 months to ensure compliance	

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F 550	Continued From page 5	F 550	and review for further recommendations and/or follow up as needed for continued compliance. Date of completion 06/09/2022.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to ensure an adaptive call light was positioned within resident's access. This was for 1 of 1 resident (Resident #38) reviewed for accommodation of needs. The findings included: Resident #38 was admitted on 11/28/17and most recently readmitted on 11/4/21 with a diagnosis of contractures. Review of Resident #38's revised care plan dated 9/17/21 read due to the inability to use a regular call light due to contractures, he required a soft touch call light to make his needs known. Interventions included ensuring the call light was placed so Resident #38 could reach it. His quarterly Minimum Data Assessment dated	F 558	On 5/9/22, during a recertification and complaint survey at Richmond Pines Healthcare and Rehabilitation Center, the survey team observed Resident #38 did not have his alternative call light (soft touch pad) within his reach. Resident #38 continues to reside at the facility and continues to require the uses of an alternative call light. On 5/12/22 Resident #38 call light was attached to his gown (chest area) and was within reach. Root Cause: Resident #38 call light was clipped to an area outside of his reach while staff were performing care. The staff forgot to move the call light back to within his reach before exiting Resident #38 room.	6/9/22

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F 558	Continued From page 6 4/18/22 indicated he was cognitively intact and was coded with impairment of range of motion (ROM) to his bilateral upper and lower extremities. An interview and observation were completed with Resident #38 on 5/9/22 at 12:26 PM. He had bilateral hand contractures and a left elbow contracture. His adaptive call light was observed clipped to the right upper top of his fitted sheet. He stated he could not get to his call light most of the time, so he had to yell out when he needed something. Resident #38 attempted to lift his right arm and hand in an effort of reach the call light but stated his arm was too stiff. He stated he often forgot to ask the staff to ensure his call light was accessible because it had been out of his reach so much, he resorted to yelling. An observation was completed on 5/10/22 at 10:51 AM of Resident #38's. His adaptive call light was observed clipped to the right upper top of his fitted sheet. An interview was conducted on 5/11/22 at 8:20 AM with Nursing Assistant (NA) #6 stated she was assigned Resident #38 on 5/9/22 and 5/10/22. She stated he used a special soft call light because of his contractures. She stated she was uncertain if he yelled out for assistance when his adaptive call light was not in reach because it only happened on occasion. An interview was completed on 5/10/22 at 12:20 PM with the ADON. She stated Resident #38 required an adaptive call light due to his hand contractures and the contracture of his left elbow. An observation was completed on 5/12/22 at	F 558	All residents have the potential to be affected by this alleged deficient practice and will be included in the corrective audits utilized for the deficient practice. On 5/17/22 through 5/20/22 the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) and assigned special project department head began & completed 100% audit of residents call lights being within reach. Any noted concerns of resident call lights out of reach were corrected during this audit by the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) and assigned special project department head. The Staff Development Coordinator (SDC), Director of Nursing (DON), Assistant Director of Nursing (ADON), and Regional Clinical Nurse Consultant will begin education 6/1/22 on ensuring resident call lights are within resident reach. This education will be completed on 6/8/22. On 6/1/22, the Housekeeping Supervisor placed clips on all resident call light cords for proper placement and ease of use by each resident. On 6/1/22, the SDC added this education to the new hire packet and agency/contract staff packet. On 6/9/22, the Staff Development Coordinator will mail education to any Contracted Agency/Facility Nursing Staff that had not completed education of	

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F 558	Continued From page 7 10:05 AM of Resident #38. His call light was clipped to the upper right side of his pillow case. He stated he was unable to reach it and had not asked anyone to move it within his reach. An observation and interview were completed on 5/12/22 at 10:40 AM of Resident #38 with NA #8 present in the room. His call light was still clipped to the upper right side of his pillow case. When questioned about Resident #38's adaptive call light placement, NA #8 stated he was unable to reach his call light where it was, and she moved the call light and clipped it to the chest area of his gown within his reach. She stated Resident #38's call light should always be within his reach. An interview was completed with the Administrator and the Director of Nursing (DON) on 5/12/22 at 1:15 PM. The DON stated she excepted Resident #38's adaptive call light remain within his reach at all times.	F 558	ensuring resident call lights are within reach. After 6/8/22, no Contracted Agency/Facility Nursing Staff will be allowed to work until education on ensuring resident call lights are within reach. Beginning 6/9/22 the Director of Nursing, Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) and assigned special project department head will complete monitoring to ensure compliance of ensuring residents receive services in the facility within reasonable accommodation for resident needs: ensure call lights are within resident reach. The Director of Nursing, the Unit Manager(s), and/or the assigned special project department head will observe six random residents 5x/week x 4 weeks, then 3x/week x4weeks, then 2x/week x4 weeks to ensure compliance that residents receive services in the facility within reasonable accommodation for resident needs: ensure call lights are within resident reach. Beginning 6/15/22 the DON or ADON will report the findings of the monitoring that residents receive services in the facility within reasonable accommodation for resident needs: ensure call lights are within resident reach to the members of the Cardinal Intradisciplinary Team once weekly x3 months to ensure compliance and review for further recommendations and/or follow up as needed for continued	

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F 558	Continued From page 8	F 558	compliance. Beginning the month of July 2022 and continuing for 3 months, the DON or ADON will report the findings of the monitoring that residents receive services in the facility within reasonable accommodation for resident needs: ensure call lights are within resident reach monthly Quality Improvement (QI) Committee meeting. The QI Committee will review for further recommendations for follow up as needed or continued compliance to determine the need and/or frequency of the continued QI monitoring to ensure compliance is maintained. Date of completion 06/09/2022.	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of restraints and alarms (Residents #25, #50, #59 and #67), bladder and bowel (Resident #78) and discharge disposition (Resident #89). This was for 6 of 24 resident records reviewed. The findings included: 1. Resident #25 was admitted to the facility on	F 641	On 5/10/22, during a recertification and complaint survey at Richmond Pines Healthcare and Rehabilitation Center, the survey team observed Resident #25, Resident #50, Resident #59, and Resident #67, Minimum Data Set (MDS) Assessment was coded incorrectly on the most recent MDS assessment to reflect a wander guard alarm. In addition, Resident #78 MDS assessment was incorrectly coded for bladder and bowel	6/9/22

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F 641	Continued From page 9 12/17/20 with diagnoses that included dementia with behavioral disturbance. Review of a nursing progress note dated 12/18/20, read "Resident #25 ambulated in the hallways frequently with a walker. She has a history of wandering and forgetfulness per family. A wander/elopement bracelet was applied to her ankle". The quarterly MDS assessment dated 2/22/22 indicated Resident #25 was able to understand others and make herself understood. She was independent with ambulation and was not coded for a wander/elopement alarm. An observation occurred of Resident #25 on 5/10/22 at 2:25 PM, ambulating in the hallways with her walker. A wander alarm was present to her ankle. On 5/12/22 at 12:26 PM, an interview occurred with the MDS Nurse. She reviewed the MDS assessment dated 2/22/22, confirmed the wander/elopement alarm was not coded and stated it was an oversight since Resident #25 had an alarm bracelet on her ankle. An interview occurred with the Director of Nursing on 5/12/22 at 1:14 PM and indicated it was her expectation for the MDS assessment to be coded accurately. 2. Resident #50 was originally admitted to the facility on 10/30/20 with diagnoses that included dementia. Review of Resident #50's active physician orders	F 641	incontinence and Resident #89 MDS assessment was incorrectly coded for discharge disposition. 1. Resident #25 continues to reside in the facility with the use of a wander guard bracelet. 2. Resident # 50 continues to reside in the facility with the use of a wander guard bracelet. 3. Resident #59 continues to reside in the facility with the use of a wander guard bracelet. 4. Resident #67 continues to reside in the facility with the use of a wander guard bracelet. 5. Resident #78 continues to reside in the facility and remains incontinent of bladder and bowel. 6. Resident #89 no longer resides at the facility. On 5/12/22 the MDS Assessment Nurse correctly coded Resident #25, Resident #50, Resident #59, and Resident #67, MDS Assessment to reflect the use of a wander guard bracelet. On 5/12/22 the MDS Assessment Nurse correctly coded Resident #78 MDS Assessment to reflect bladder and bowel incontinence. Root Cause: MDS Assessment nurse overlooked coding 4 residents with wander guard bracelets and miscoded one resident bladder and bowel incontinence and miscoded one resident discharge disposition in error.	

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F 641	Continued From page 10 revealed an order dated 1/11/22 for a wander-guard bracelet. A quarterly MDS assessment dated 3/15/22 indicated Resident #50 had moderately impaired cognition and was not coded for a wander/elopement alarm. On 5/9/22 at 10:15 AM, an observation occurred of Resident #50 while she was sitting in a chair in the TV lounge. A wander-alarm bracelet was visible to her right ankle. On 5/12/22 at 12:26 PM, an interview occurred with the MDS Nurse. She reviewed the MDS assessment dated 3/15/22 and confirmed the wander/elopement alarm was not coded. She stated it was an oversight since Resident #50 had an alarm bracelet on her ankle. An interview occurred with the Director of Nursing on 5/12/22 at 1:14 PM and indicated it was her expectation for the MDS assessment to be coded accurately. 3. Resident #59 was originally admitted to the facility on 4/23/21 with diagnoses that included dementia. A review of Resident #59's active physician orders revealed an order dated 4/27/21 for a wander guard bracelet for safety and to check placement every shift. A quarterly MDS assessment dated 4/22/22 indicated Resident #59 had severely impaired cognition and was not coded for a wander/elopement alarm.	F 641	All residents have the potential to be affected by this alleged deficient coding practice. On 6/1/22, the Regional MDS Nurse Consultant completed 100% audit of residents requiring wander guard bracelets were coded correctly in MDS. On 6/1/22, the Regional MDS Nurse Consultant completed a 90 day 100% audit of discharged residents and found that they were coded correctly in MDS. On 6/2/22, the Regional Director of Clinical Services completed a 100% audit of continent/incontinent residents to ensure bowel and bladder continent/incontinent is coded correctly. On 6/1/22 the Regional MDS Nurse Consultant educated MDS nurse and intradisciplinary team on accuracy of MDS Coding. Beginning 6/10/22 the Assistant Director of Nursing, Regional Clinical Nurse Consultant, and Regional MDS will begin auditing 100% of MDS to ensure accuracy of coding prior to MDS submitting MDS. This 100% audit will cover all residents since all could potentially be affected in regard to MDS coding accuracy. Beginning 6/17/22 the Assistant Director of Nursing will report the findings of the monitoring of MDS coding accuracy to the members of the Cardinal Intradisciplinary Team once weekly x 3 months to ensure compliance and review for further recommendations and/or follow up as	

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RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345

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F 641	Continued From page 11 On 5/9/22 at 12:35 PM, an observation occurred of Resident #59 while she was sitting with a wander-alarm bracelet visible to her right ankle. On 5/12/22 at 12:26 PM, an interview occurred with the MDS Nurse. She reviewed the MDS assessment dated 4/22/22 and confirmed the wander/elopement alarm was not coded. She stated it was an oversight since Resident #59 had an alarm bracelet on her ankle. An interview occurred with the Director of Nursing on 5/12/22 at 1:14 PM and indicated it was her expectation for the MDS assessment to be coded accurately. 4. Resident #67 was admitted to the facility on 4/11/16 with diagnoses that included dementia. A review of Resident #67's active physician orders revealed an order dated 4/4/22 to check wander-guard placement to the ankle every shift. A quarterly MDS assessment dated 4/4/22 indicated Resident #67 had severely impaired cognition and was not coded for a wander/elopement alarm. A review of Resident #67's active care plan, last reviewed on 4/18/22, included a focus area for wandering and/or at risk for unsupervised exits from the facility related to impaired cognition. One of the interventions was for a wander-guard alarm bracelet, that was initiated on 6/12/19. On 5/9/22 at 10:00 AM, an observation occurred of Resident #67 while he was lying in bed with a	F 641	needed for continued compliance. Beginning the month of July 2022 and continuing for 3 months, the Assistant Director of Nursing will report the findings of the monitoring of MDS coding accuracy to the monthly Quality Improvement (QI) Committee meeting. The QI Committee will review for further recommendations for follow up as needed or continued compliance to determine the need and/or frequency of the continued QI monitoring to ensure compliance is maintained. Date of completion 06/09/2022.	

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wander-alarm bracelet to his ankle.

On 5/12/22 at 12:26 PM, an interview occurred with the MDS Nurse. She reviewed the MDS assessment dated 4/4/22 and confirmed the wander/elopement alarm was not coded. She stated it was an oversight since Resident #67 had an alarm bracelet on his ankle.

An interview occurred with the Director of Nursing on 5/12/22 at 1:14 PM and indicated it was her expectation for the MDS assessment to be coded accurately.

5. Resident #78 was admitted on 10/11/18 with a diagnosis of a Cerebral Vascular Accident.

Review of Resident #78's previous quarterly Minimum Data Sets (MDS) dated 12/3/21 and 1/26/22 indicated he was incontinent of bowel.

His most recent quarterly MDS dated 4/13/22 indicated he was continent of bowel.

Resident #78 was care planned 10/24/18 last revised 2/15/22 for toileting assistance due to incontinence related to his left sided weakness.

An interview was conducted with Nursing Assistant (NA) #9 on 5/11/22 at 5:00 PM. She stated that she had worked with Resident #78 and that he has been incontinent of bowel for as long as she could recall.

An interview was conducted with NA #10 on 5/11/22 at 5:05 PM. She stated Resident #78 was incontinent of bowel for as long as she could recall.

An interview was conducted with the MDS Nurse

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on 5/12/22 at 12:26 PM. She stated she was aware that she had incorrectly noted Resident #78's bowel status and this had been an oversight. She explained she had completed a modification to the quarterly MDS dated 4/13/22 on 5/11/22.

An interview was completed with the Administrator on 5/12/22 at 1:15 PM. She stated she expected Resident #78's MDS to be completed accurately.

6. Resident #89 was admitted 12/15/2021 from the acute hospital setting.

Resident #89's discharge Minimum Data Set (MDS) dated 2/15/2022 indicated the resident was discharged to acute hospital setting and return was not anticipated.

The discharge summary, dated 2/15/2022, with medications, physical therapy orders, and recapitulation of stay was reviewed. The discharge summary indicated Resident #89 was discharged to home.

The resident's medical record indicated the resident was discharged home with her daughter on 2/15/2022 with home health services.

Resident #89's medical record also contained a progress note by the social worker dated 2/21/2022 that indicated a follow up call was made to the resident's daughter to confirm home health care was in place and resident received physical therapy services at home.

On 2/11/2022 at 2:11 PM and interview was conducted with the MDS nurse. She stated she had been working as MDS nurse for

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F 641	Continued From page 14 approximately one year. She reviewed Resident #89's discharge MDS dated 2/15/2022 and stated the discharge was coded for acute hospital setting with return not anticipated. She reviewed the resident's discharge summary and stated the MDS was coded in error. The MDS should have been coded to reflect the resident was discharged to home. On 5/12/2022 at 1:14 PM and interview was conducted with the Director of Nursing (DON). She stated it was her expectation MDS be coded accurately.	F 641		
F 677 SS=E	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, staff, resident and family interviews and record review, the facility failed to provide shaving assistance for Resident #17 and Resident #34 dependent on assistance with activities of daily living (ADLs). The facility also failed to provide nail care for ADL dependent residents (Resident #17, Resident #38, Resident #78, Resident #34 and Resident #26). This was for 5 of 20 residents reviewed for ADLs. The finding included: 1. Resident #17 was admitted on 6/26/21 and readmitted on 2/19/22 with cumulative diagnoses of Peripheral Vascular Disease (PVD) and End Stage Renal Disease (ESRD).	F 677	On 5/12/22, during a recertification and complaint survey at Richmond Pines Healthcare and Rehabilitation Center, the survey team noted the facility failed to provide desired ADL care for the following: 1. Resident #17 continues to reside in the facility and continues to require assistance with ADLs: shaving and nail care. 2. Resident #38 continues to reside in the facility and continues to require assistance with ADLs: nail care. 3. Resident #78 continues to reside in the facility and continues to require assistance with ADLs: nail care.	6/9/22

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F 677	Continued From page 15 His readmission Minimum Data Set dated 2/26/22 indicated he was cognitively intact, exhibited no behaviors and he required extensive staff assistance with his personal hygiene. Resident #17 was care planned on 2/20/22 for assistance with his ADLs but the care plan did not include assistance with personal hygiene. An observation and interview was completed with Resident #17 on 5/9/22 at 2:40 PM. His fingernails were observed with a dark substance underneath and the nails extended past his fingertips. Resident #17's facial hair was disheveled, long and extended down onto his neck. He stated he only preferred a mustache but not the beard. He stated he could not remember the last time he had a shave or had his fingernails trimmed. An observation was completed on 5/10/22 at 10:15 AM with the Treatment Nurse (TN) and the Assistant Director of Nursing (ADON) providing wound care. The TN and ADON did not mention the appearance of his fingernails or facial hair. An interview was completed on 5/10/22 at 12:20 PM with the ADON. She stated the aides provided all fingernail care and shaving during ADLs and it should be done as needed or noticed. An interview was completed on 5/11/22 at 8:35 AM with Nursing Assistant (NA) #6. She confirmed she was assigned Resident #17 on 5/9/22 and 5/10/22 but she did not notice his fingernails or facial hair. NA #6 stated nail care and shaving was completed by the aides as needed. She stated she was not aware of any refusals of assistance with his ADLs.	F 677	4. Resident # 67 continues to reside in the facility and continues to require assistance with ADLs: shaving and nail care. 5. Resident #26 continues to reside in the facility and continues to require assistance with ADLs: nail care. 1. On 5/11/22 Resident #17 was shaved, and nail care provided by facility nursing staff 2. On 5/10/22 Resident #38 was provided nail care by the Assistant Director of Nursing (ADON). 3. On 5/11/22 Resident #78 was provided nail care by facility nursing staff. 4. On 5/10/22 Resident #67 was shaved (mustache remained as Resident #67 preference), and nail care provided by facility nursing staff. 5. On 5/10/22 Resident #26 was provided nail care by the assigned nurse. Root Cause: Nursing staff were not offering/performing ADL care (shaving assistance or nail care) per facility expectations for dependent residents due to staff unclear of facility expectations on assistance of ADL care for dependent residents and staff role of assistance. Shaving and/or nail care coincide with shower days and as needed. Any nurse aide, nurse and/or current Activities staff is expected to provide this type of ADL care when the corrective audits deem necessary. All residents have the potential to be affected by this alleged deficient practice.	

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F 677	Continued From page 16 An interview was completed on 5/11/22 at 8:55 AM with the ADON. She stated Resident #17 did not refuse assistance with his ADLs. An interview and observation was completed on 5/11/22 at 11:13 AM. Resident #17 was in his room with his wife present. He appeared unshaven and his fingernails had not trimmed. His wife stated Resident #17 never wore a beard but only a mustache and he never allowed his fingernails to extended past his fingertip. She stated he needed assistance with shaving and trimming his nails and was uncertain why the aides had not assisted him with his personal hygiene. An interview was completed on 5/11/22 at 11:22 AM with NA #8. She stated the night shift aides completed Resident #17's ADLs in order for him to be ready for dialysis but she would shave his face and trim his fingernails today. Attempts to contact NA #11 assigned Resident #17 third shift on 5/9/22, 5/10/22 and 5/11/22 were unsuccessful. An observation was conducted on 5/11/22 at 5:07 PM. Resident #17 appeared clean shaven except for his mustache and his fingernails had been trimmed and cleaned. He stated he felt much improved. An interview was completed with the Administrator and the Director of Nursing (DON) on 5/12/22 at 1:15 PM. The DON stated she expected the staff to assist Resident #17 with shaving and nail care as needed.	F 677	On 5/10/22 through 5/12/22 the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) and assigned special project department head began & completed 100% audit of ADL care/assistance for dependent residents (shaving and nail care). Any noted concerns of residents requiring ADL care/assistance for dependent residents (shaving and nail care) were corrected during this audit by the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC), assigned special project department head, and nursing staff. Additionally, all residents who refused shaving and/or nail care were care-planned for refusals by the MDS Coordinator. The Staff Development Coordinator (SDC), Director of Nursing (DON), Assistant Director of Nursing (ADON), and Regional Clinical Nurse Consultant will begin education on 6/1/22 on ensuring ADL care/assistance for dependent residents (shaving and nail care) is performed on shower days and as needed by Certified Nursing Assistant (CNA), assigned nurse, or assigned department head. This education will be completed on 6/8/22. On 6/1/22 the SDC added this education to the new hire packet and agency/contract staff packet. On 6/9/22 the Staff Development Coordinator will mail education to any	

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F 677	Continued From page 17 2. Resident #38 was admitted on 11/28/17and most recently readmitted on 11/4/21 with cumulative diagnoses neurogenic bladder and contractures. Resident #38 was care planned on 10/4/18 last revised 9/17/21 for total assistance with his personal hygiene due to his contracture to his left upper extremity. He was also care planned on 4/8/19 last revised 9/41/21 for resistance to care and treatments and was known to refuse medications, treatments and showers at times. Interventions included allowing flexibility in his ADL routine to accommodate his mood. His quarterly Minimum Data Assessment dated 4/18/22 indicated he was cognitively intact, exhibited rejection of care and coded for total assistance with all of his activities of daily living (ADLs). An interview and observation was completed with Resident #38 on 5/9/22 at 12:26 PM. He had bilateral hand contractures and a left elbow contracture. His appeared fingernails jagged, extended beyond his fingertips and had a dark looking substance under the nails. He stated the staff had to trim his fingernails and could not recall when they were last trimmed. An observation of wound care was completed on 5/10/22 at 11:20 AM with the Treatment Nurse (TN) and the Assistant Director of Nursing (ADON). Neither the TN nor the ADON noticed the appearance of Resident #38's fingernails. An interview was completed on 5/10/22 at 12:20 PM with the ADON. She stated the aides provided	F 677	Contracted Agency/Facility Nursing Staff that had not completed education of ensuring ADL care/assistance for dependent residents (shaving and nail care) is performed on shower days and as needed by Certified Nursing Assistant (CNA), assigned nurse, or assigned department head. After 6/8/22, no Contracted Agency/Facility Nursing Staff will be allowed to work until education on ensuring res ADL care/assistance for dependent residents (shaving and nail care) is performed on shower days and as needed by Certified Nursing Assistant (CNA), assigned nurse, or assigned department head. Beginning 6/9/22 the Director of Nursing, Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) and assigned special project department head will complete monitoring to ensure compliance of ensuring ADL care/assistance for dependent residents (shaving and nail care) is performed on shower days and as needed by Certified Nursing Assistant (CNA), assigned nurse, or assigned department head. The Director of Nursing, the Unit Manager(s), and /or the assigned special project department head will observe 6 random residents 5x/week x 4 weeks, then 3x/week x 4 weeks, then 2x/week x 4 weeks to ensure compliance that ADL care/assistance for dependent residents (shaving and nail care) is performed on shower days and as needed by Certified	

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F 677	Continued From page 18 all fingernail care during ADLs and it should be done as needed or noticed. An interview was conducted on 5/11/22 at 8:20 AM with Nursing Assistant (NA) #6 stated she was assigned Resident #38 on 5/9/22 and 5/10/22 but she did not observe the condition of his fingernails. She stated she had not known Resident #38 to refuse his nail care but he would say his fingernails were sensitive and picky about who he allowed to trim them. NA #6 stated the ADON trimmed and cleaned his fingernails yesterday. An interview and observation was completed on 5/11/22 at 8:35 AM. NA #7 was assisting Resident #38 with his breakfast. He stated the ADON trimmed his fingernails yesterday and they felt better because when his fingernails grew out as long as they were yesterday, they become very sensitive. NA #7 stated nail care should be done when needed. She stated Resident #38 did not refuse nail care or personal hygiene assistance. An interview was completed with the Administrator and the Director of Nursing (DON) on 5/12/22 at 1:15 PM. The DON stated she expected the staff to assist Resident #38 with nail care as needed. 3. Resident #78 was admitted on 10/11/18 with a diagnosis of a Cerebral Vascular Accident. His quarterly Minimum Data Set (MDS) dated 4/13/22 indicated Resident #78 was cognitively intact, exhibited no behaviors and was coded for extensive staff assistance with his personal hygiene.	F 677	Nursing Assistant (CNA), assigned nurse, or assigned department head. Beginning 6/15/22 the Director of Nursing, Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) and assigned special project department head will report the findings of the monitoring ADL care/assistance for dependent residents (shaving and nail care) is performed on shower days and as needed, to the members of the Cardinal Intradisciplinary Team once weekly x3 months to ensure compliance and review for further recommendations and/or follow up as needed for continued compliance. Beginning the month of July 2022 and continuing for 3 months, the DON or ADON will report the findings of the monitoring that ADL care/assistance for dependent residents (shaving and nail care) is performed on shower days and as needed, monthly Quality Improvement (QI) Committee meeting. The QI Committee will review for further recommendations for follow up as needed or continued compliance to determine the need and/or frequency of the continued QI monitoring to ensure compliance is maintained. Date of completion 06/09/2022.	

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Resident #78 was care planned on 10/24/18 last revised 12/20/19 for assistance with his personal hygiene due to left sided weakness.

An interview and observation was completed on 5/09/22 1:36 PM with Resident #78. His fingernails extended past his fingertips and appeared for have a dark substance underneath his fingernails. He stated he needed the staff to trim his nails but he always forgot to ask.

An observation was completed on 5/10/22 at 3:55 PM. He was sitting in a wheelchair outside in the hall near the doorway of his room. The appearance of his fingernails were unchanged.

An interview was completed on 5/11/22 at 5:00 PM with Nursing Assistant (NA) #9. She stated Resident #78 was only known to refuse showers but he did not refuse assistance with his personal hygiene or nail care.

An interview was completed on 5/11/22 at 5:05 PM with NA #10. She stated Resident #78 was known to refuse ADL assistance but would agree to allow staff to assist him in his time.

An interview was completed with the Administrator and the Director of Nursing (DON) on 5/12/22 at 1:15 PM. The DON stated she expected the staff to assist Resident #78 with nail care as needed.

4. Resident #34 was originally admitted to the facility on 9/28/21 with diagnoses that included heart disease and urinary retention.

A quarterly Minimum Data Set (MDS) assessment dated 3/1/22, indicated Resident #34

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was cognitively intact and was coded with no behaviors or refusal of care. He required extensive assistance with personal hygiene and bathing.

A review of Resident #34's active care plan, last reviewed 3/14/22, included a focus area for activities of daily living/personal care. The interventions included to provide extensive assistance with tasks such as combing hair and shaving.

A review of the nursing progress notes from 12/31/21 to 5/9/22, revealed no refusals of nail care or shaving assistance documented.

An interview and observation was made of Resident #34 on 5/9/22 at 1:15 PM while he was sitting on the side of the bed. He was noted with a thick, long beard and long fingernails with a brown substance under them to both hands. Resident #34 stated it had been awhile since he was shaved and normally wore only a moustache. Stated he would like to be shaved but could not recall being offered. In addition, Resident #34 stated "I've never kept my fingernails this long. They just cut my toenails not long ago, but not sure why they haven't done my fingernails".

On 5/10/22 at 11:09 AM, Resident #34 was observed lying in bed. He stated no one had offered to shave him or cut his fingernails.

The Assistant Director of Nursing (ADON) was interviewed on 5/10/22 at 3:15 PM and stated nail care was provided when needed. She observed Resident #34 and stated his fingernails did need to be cut and cleaned. She was unable to state why he had not been shaven or had his

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fingernails cared for during personal care assistance.

Nurse Aide (NA) #1 was interviewed on 5/10/22 at 3:51 PM and explained nail care and shaving assistance was completed on shower days, when needed or requested by the resident. She further stated if a resident refused the nurse would be informed so a progress note could be written. She was unaware of any refusals from Resident #34.

Resident #34 was observed on 5/11/22 at 10:43 AM. His face was clean shaven with a moustache remaining and his fingernails were short and clean. Resident #34 stated someone came by the prior evening and assisted with shaving and caring for his fingernails and added he felt "much better".

On 5/12/22 at 9:45 AM, NA #3 was interviewed. She indicated she was familiar with Resident #34. She explained nail care and shaving assistance should have occurred during personal care, shower days and when needed but was unable to state why Resident #34 had not been offered nail care or shaving assistance prior to 5/10/22.

The Director of Nursing (DON) was interviewed on 5/12/22 at 1:15 PM and indicated it was her expectation for NAs to monitor, clean and trim nails during personal care, retrieving a nurse if the resident was a diabetic or refused. Additionally, the DON stated it was her expectation that Resident #34 be free of unwanted facial hair and expected NAs to offer shaving assistance during his scheduled shower days and during personal care tasks.

5. Resident #26 was admitted to the facility on

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RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345

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F 677	Continued From page 22	F 677		

12/21/2017 with diagnosis that included intellectual disabilities.

The resident's quarterly Minimum Data Set (MDS) dated 2/22/2022 indicated Resident #26 was severely cognitively impaired and nonverbal. The resident was dependent on staff for all activities of daily living including eating, dressing, toileting, and personal hygiene during the assessment period. Resident #26 was not coded for moods or behaviors and did not reject care during the assessment period.

Resident #26's comprehensive care plan dated 3/9/2022 contained a focus for skin impairment related to having fragile skin and scratching himself. Interventions included checking fingernails frequently and keeping fingernails trimmed and filed as needed.

During an observation of wound care on 5/10/2022 at 3:43 PM the Assistant Director of Nursing (ADON) and the Treatment nurse were present. The Treatment nurse stated the resident had scratched his buttocks on 5/9/2022 and had a new area of broken skin. The resident's incontinent brief was clean and dry when removed. The bilateral buttocks were observed to have blanchable redness and the right buttock had broken skin in long linear patterns. The ADON was asked to examine the resident's fingernails. The fingernails on both hands were observed to be long and had a brown substance under the nails. The resident also had a brown substance on the palm of his left hand. The ADON stated the resident needed his nails cleaned and trimmed. She further stated nail care was provided as needed by the staff.

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F 677	Continued From page 23 On 5/10/2022 at 3:51 PM an interview was conducted with Nursing Assistant (NA) #1. She stated she was assigned to Resident #26. She stated fingernails were checked and trimmed as needed on shower days. She stated she had not trimmed Resident #26's fingernails recently and she did not know what day he got showers. She further stated she saw that the resident's nails and hands were dirty. She was going to clean his hands and nails after she answered another resident's call bell. On 5/12/2022 at 1:14 PM an interview was conducted with the Dirctor of Nursing (DON). She stated she expected the NAs to monitor, clean , and trim nails when they provided personal care.	F 677		
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 record reviews, observations, resident, staff and physician interviews, the facility failed to provide surgical wound care as ordered for 1 of 3 residents reviewed for non-pressure related wound care (Resident #40). The findings included:	F 684	On 5/12/22, during a recertification and complaint survey at Richmond Pines Healthcare and Rehabilitation Center, the survey team noted the facility failed to provide surgical wound care as ordered for resident #40. Resident #40 continues to reside at the	6/9/22

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F 684	Continued From page 24 Resident #40 was originally admitted to the facility on 1/3/22 with a readmission date of 1/18/22. His diagnoses included necrotizing fasciitis (a severe soft tissue infection that is caused by bacteria), abscess of the perineum, and type 2 diabetes. The nursing progress notes were reviewed from 1/3/22 to 5/8/22 and indicated Resident #40 had no episodes of refusal of wound care. A physician progress note dated 1/21/22 indicated Resident #40 had been hospitalized for an abscess in the right perineum and right buttock, which was surgically debrided and consistent with necrotizing soft tissue infection. A quarterly Minimum Data Set (MDS) assessment dated 3/17/22 indicated Resident #40 was cognitively intact and had surgical wounds present. Review of a Wound Clinic assessment dated 3/25/22 revealed the perineal surgical wound measured 8.2 centimeters (cm) in length, 0.5 cm in width and 0.5cm in depth. There was tunnelling at three o'clock with a maximum distance of 3 cm. The right buttock surgical wound measured 1.8 cm in length, 0.3 cm in width and 2 cm in depth. There was tunnelling at three o'clock with a maximum distance of 3 cm. Resident #40's active care plan, last reviewed 3/31/22, revealed a focus area for potential for/actual skin integrity impairment: diabetic/neuropathic ulcers related to: diabetic ulcer to foot, left buttock surgical incision. The interventions included to provide treatments as ordered.	F 684	facility, continues to require to be seen by the Wound Clinic for surgical wound healing and licensed provider orders for treatment. On 5/27/22 Resident #40 was seen at the Wound Clinic with notes from the Wound Care Provider of improvement to Resident #40 wounds. Root Cause: Staff nurse not performing wound care per licensed provider orders, nor were the nurses reporting to on-coming nurse to provide the wound care per wound care providers orders that had not been completed on the off-going shift. The staff nurse also did not document completion of ordered wound treatment on occasion. In addition, the staff nurse did not report to the facility licensed provider or to the wound care licensed provider of missed wound care treatments for additional orders. All residents with wounds have the potential to be affected by this alleged deficient practice. On 5/17/22 through 5/20/22 the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) and assigned special project department head began & completed 100% audit of residents requiring wound care to ensure orders were in place and being followed. Facility Licensed Providers and/or Wound Care Licensed Providers were notified of any concerns of wound care orders not being	

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F 684	Continued From page 25 A review of a Wound Clinic assessment dated 4/1/22 revealed Resident #40's open surgical wound to the perineum measured 5 cm in length, 0.3 cm in width and 0.3 cm in depth. There was no tunneling present. The right buttock open surgical wound measured 1 cm in length, 0.2 cm in width and 0.5 cm in depth. There was tunneling at three o'clock with a maximum distance of 2.9 cm. There was no necrotic (dead) tissue in the wound bed. A review of the active physician orders for Resident #40, revealed the following orders dated 4/1/22: - Clean the perineal wound with normal saline using gauze, pat dry with clean gauze, apply Calcium Alginate with Silver (a highly absorbent gel-like covering to help maintain a moist environment that promotes wound healing) and secure every day. - Clean the right buttock wound with normal saline using gauzes, pat dry with clean gauze, apply Calcium Alginate with Silver and secure every day. A review of a Wound Clinic assessment dated 4/8/22 revealed Resident #40's open surgical wound to the perineum measured 8 cm in length, 1 cm in width and 0.5 cm in depth. There was no tunneling present. The right buttock open surgical wound measured 1.5 cm in length, 0.5 cm in width and 3 cm in depth. There was no tunneling or necrotic tissue in the wound bed. The April 2022 Treatment Administration Record (TAR) was reviewed and demonstrated the surgical wound care to Resident #40's perineum and right buttock were not initialed as completed on 4/23/22, 4/24/22 and 4/30/22 at 9:00 AM.	F 684	followed. Any new orders for wound care by the Facility/Wound Care Licensed Providers were processed and are being followed by the nursing staff. The Staff Development Coordinator (SDC), Director of Nursing (DON), Assistant Director of Nursing (ADON), and Regional Clinical Nurse Consultant will begin education on 6/1/22 on ensuring resident wound care orders are being followed. This education included informing nurses and medications aides on checking for omissions in EMAR/ETAR prior to leaving for the shift or accepting the cart for the on-coming shift. This education will be completed by 6/9/22. On 6/1/22, the SDC added this education to the new hire packet and agency/contract staff packet. After 6/9/22, no Contracted Agency/Facility Nursing Staff will be allowed to work until education on ensuring resident wound care orders are being followed and checking for omissions in EMAR/ETAR prior to leaving for the shift or accepting the cart for the on-coming shift Beginning 6/2/22, the Clinical Intradisciplinary Team/Nursing Supervisor will review the report for omissions in EMAR/ETAR via the Medication Administration Audit Report via the EMAR/ETAR system daily to ensure wound care is completed for all residents with wounds. Any concerns will be corrected at that time. The Director of	

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F 684	Continued From page 26 On 5/12/22 at 9:20 AM, an interview was completed with the Staff Development Coordinator (SDC) who was assigned to Resident #40 on 4/24/22. She explained nursing staff were responsible for wound care when the treatment nurse wasn't present and normally the weekend supervisor (Nurse #4) completed the wound care on the weekends. The SDC further stated the weekend supervisor had been on medical leave since 4/20/22 and had not returned to work yet. The SDC reviewed Resident #40's April 2022 TAR and stated she didn't provide any wound care on 4/24/22 to the perineal or right buttock surgical wound, because she was "covering the house and pushing a cart" and thought the second shift (3:00 PM to 11:00 PM) nurse would complete the care. A phone interview occurred with Nurse #6 on 5/12/22 at 9:32 AM. She was the nurse assigned to Resident #40 on the second shift on 4/24/22. She could not recall being told the wound care had not been completed that morning and stated the electronic TAR did not show the wound care was needed for her shift. Nurse #6 explained she was asked by Resident #40 to change the dressing on his perineal wound, which she did, and a progress note was written, but she did not change the right buttock surgical wound dressing as she was under the impression it had already been completed on the day shift as ordered. Review of a nursing progress note written by Nurse #6 and dated 4/24/22, indicated per Resident #40's request the perineal surgical wound was cleansed and wound care was provided.	F 684	Nursing, the Assistant Director of Nursing and /or the assigned special project department head will monitor the Medication Administration Audit Report via the EMAR/ETAR system daily x3 months to ensure compliance that all resident wound care orders are being followed as prescribed. Beginning 6/2/22 the Clinical Intradisciplinary Team/Nursing Supervisor will review the report for omissions in EMAR/ETAR via the Medication Administration Audit Report via the EMAR/ETAR system daily. Any concerns will be corrected at that time. DON or ADON will report the findings of the monitoring that EMAR/ETAR system daily to ensure compliance that resident wound care orders are being followed to the members of the Cardinal Intradisciplinary Team once weekly x3 months to ensure compliance and review for further recommendations and/or follow up as needed for continued compliance. Beginning the month of July 2022 and continuing for 3 months, the DON or ADON will report the findings of the monitoring that residents receive wound care as ordered: monthly Quality Improvement (QI) Committee meeting. The QI Committee will review for further recommendations for follow up as needed or continued compliance to determine the need and/or frequency of the continued QI monitoring to ensure compliance is maintained.	

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F 684	Continued From page 27 The May 2022 TAR was reviewed and revealed the surgical wound care to Resident #40's perineum and right buttock were not initialed as completed on 5/1/22, 5/7/22 or 5/8/22 at 9:00 AM. On 5/11/22 at 2:50 PM, an interview was conducted with Nurse #1, who had been assigned to Resident #40 on 4/30/22 and 5/1/22. She stated she could not recall completing any wound care for Resident #40's perineal or right buttock surgical wounds and was unaware he had any wound orders. Multiple attempts were made during the course of the survey to contact Nurse #4, who was the weekend supervisor; Nurse #5, who was assigned to Resident #40 on 4/23/22; and Nurse #7, who was assigned to Resident #40 on 5/7/22 and 5/8/22, without success. A review of the Wound Clinic assessment dated 5/6/22 indicated Resident #40's open surgical wound to the perineum measured 3.5cm in length, 0.4 cm in width and 0.1 cm in depth. The right buttock open surgical wound was healed with all measurements at zero. The Treatment Nurse was interviewed on 5/9/22 at 3:45 PM and explained he completed wound care dressing changes Monday through Friday on the day shift (7:00 AM to 3:00 PM) and that nursing staff were responsible for completing their own wound care in the afternoon and evening shifts, if there was a need, as well as on the weekend. Another interview occurred with the Treatment Nurse on 5/11/22 at 4:50 PM. He reiterated nursing staff were responsible for wound care	F 684	Date of completion 06/09/2022.	

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when he was not on duty as well as on the weekend and stated normally on the weekends the nursing supervisor completed wound care but had been out for several weeks.

An observation of Resident #40's surgical wound care occurred on 5/10/22 at 2:33 PM with the treatment nurse and Assistant Director of Nursing (ADON). Resident #40 had an open surgical wound to the right posterior perineal area that had a small amount of brown drainage on the dressing and minimal odor. The wound bed was beefy red with no necrotic areas observed. Wound care was completed as ordered. The surgical wound to the right buttock area was healed.

An interview occurred with Resident #40 on 5/11/22 at 12:00 PM. He was up in his wheelchair at bedside and stated that for the "last month or so" his surgical wound care had not been completed on the weekend as it was during the week. Resident #40 indicated the lack of wound care had occurred as recently as the weekend of 5/7/22 and 5/8/22. When he asked for someone to change the dressings he would be told they would be there soon.

On 5/12/22 at 1:15 PM, an interview was held with the Director of Nursing (DON). She explained the facility had recently transitioned from paper to electronic TAR's on 4/19/22. The DON stated she was unaware surgical wound care was not provided to Resident #40 as ordered. She expected the nurses on day shift to report any wound care that had not been completed to the oncoming shift so it could be completed as well as all nursing staff to review the TARs for any needed wound care. The DON

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F 684	Continued From page 29 added a better system needed to be put into place to prevent wound care being missed as ordered. On 5/11/22 at 9:45 AM, an interview was completed with the Medical Director. The missing documentation for the April and May 2022 TARs were reviewed. The Medical Director stated he had not been informed the surgical wound care was not completed as ordered on the days no initials were present and stated he would have expected nursing staff to complete the wound care as ordered and document that it was done. Attempts were made to speak to the Wound Clinic during the course of the survey which were unsuccessful.	F 684		
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: Based on observations, staff and Medical	F 686	On 5/9/22, during a recertification and	6/9/22

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F 686	Continued From page 30 Director (MD) interviews and record review, the facility failed to ensure MD ordered specialty air mattress was set according to the weight of the resident (Resident #30 and Resident #38). The facility also failed to ensure the MD ordered air mattress was implemented for Resident #26. This was for 3 of 3 residents reviewed for pressure ulcers. The findings included: 1. Resident #30 was admitted 3/3/22 cumulative diagnoses of a Urinary Tract Infection (UTI), urinary retention and a pressure ulcer to his sacrum. His admission Minimum Data Set (MDS) dated 3/10/22 indicated he was cognitively intact. He was coded for a urinary catheter, 2 stage one pressure ulcers and coded for a pressure relieving device to his bed. The MDS read Resident #30's admission weight was 190 pounds. Resident #30 was care planned on 3/4/22 for the risk of development of further pressure ulcers and the redness to his right and left buttocks. Interventions included ensuring the appropriate pressure relieving devices were in place. Review of Resident #30's skin assessment dated 3/29/22 indicated his stage 1 pressure ulcer to his left buttock had opened. Review of Resident #30's skin assessment dated 4/15/22 indicated the area to his left buttock progressed to a stage 3 and his skin assessment dated 4/22/22 indicated the area was unchanged.	F 686	complaint survey at Richmond Pines Healthcare and Rehabilitation Center, the survey team observed Resident #30, and Resident #38 Alternating Air Mattress (AAM) was not on the correct settings per resident weight. Survey team also noted Resident #26 AAM was not implemented per Licensed Provider order. 1. Resident #30 no longer resides at the facility. 2. Resident #38 continues to reside at the facility and requires the use of an AAM. 3. Resident #26 continues to reside at the facility and does not require the use of an AAM. On 5/12/22 Resident #38 AAM settings were adjusted per Resident #38 weight as per manufacture recommendations and these settings were added to the EMAR to be checked and adjusted each shift as needed by the assigned nurse/medication aide. On 5/12/22 Resident #26 AAM was removed from the EMAR per clarification from the Licensed Provider. Root Cause: Resident #38 AAM settings were not checked and adjusted per resident weight by nurses/medication aides. Resident #26 was a transcription error to EMAR from paper MAR All residents have the potential to be affected by this alleged deficient practice. On 5/17/22 through 5/20/22 the Director of Nursing (DON), Assistant Director of	

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F 686	Continued From page 31 The MD ordered Resident #30 to be referred to the wound clinic due to increased drainage on 4/25/22. Review of Resident #30's wound consult dated 5/2/22 indicated the area on his left buttock was described as his sacrum. The area was debrided and a new order for an alternating air mattress (AAM). Review of a MD order dated 5/9/22 read for Resident #30 to be placed on an air mattress and to validate AAM setting range weekly on every Tuesday. Resident #30's electronic medical record read the last weight for Resident #30 was 182 pounds on 4/13/22. An interview was conducted with Resident #30 on 5/9/22 at 11:46 AM. He stated the air mattress was added to his bed while he was out for his wound clinic appointment earlier this morning. Observation of the AAM indicated the weight was set at 400 pounds. An observation of Resident #30's AAM was completed on 5/10/22 at 10:35 AM. The Treatment Nurse (TN) was present but did not noticed the AAM was set for the weight of 400 pounds. He stated that all ordered AAM's should be set accurately based on the resident's weight. An interview was conducted with Nursing Assistant (NA) #6 on 5/10/22 at 10:45 AM. She stated the aides were not responsible for setting up or checking the AAM for function or settings. She stated to her knowledge, it was either the responsibility of the floor nurse or the TN.	F 686	Nursing (ADON), Staff Development Coordinator (SDC) and assigned special project department head began & completed 100% audit of resident mattress to ensure correct orders for specialty mattress were in place. These audits also included any specialty mattresses were correct on the EMAR and AAM settings were being checked each shift. The Staff Development Coordinator (SDC), Director of Nursing (DON), Assistant Director of Nursing (ADON), and Regional Clinical Nurse Consultant will begin education on 6/1/22 on ensuring orders for specialty mattresses are correct on EMAR and AAM settings are checked & corrected per resident weight as needed. This education will be completed on 6/8/22. On 6/1/22, the SDC added this education to the new hire packet and agency/contract staff packet. On 6/9/22, the Staff Development Coordinator will mail education to any Contracted Agency/Facility Nursing Staff that had not completed education of ensuring orders for specialty mattresses are correct on EMAR and AAM settings are checked & corrected per resident weight as needed. After 6/8/22, no Contracted Agency/Facility Nursing Staff will be allowed to work until education on ensuring orders for specialty mattresses are correct on EMAR and AAM settings are checked & corrected per resident	

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F 686	Continued From page 32 An interview was conducted with the Staff Development Coordinator (SDC) on 5/10/22 at 10:47 AM. She stated it was the responsibility of the floor nurses to ensure any AAM's function and setting were accurate. An interview was conducted with Nurse #1 on 5/10/22 at 11:10 AM. She stated she was not sure who was responsible for ensuring AAM's were functioning properly and the air mattress pump settings were accurate based on the resident's weight. She stated she was under the impression that the TN and Assistant Director of Nursing (ADON) did it since they did wound rounds together weekly. An interview was conducted with the ADON on 5/10/22 at 11:15 AM. She confirmed she and the TN performed weekly wound assessments. The ADON stated during the wound rounds, the AAM was assessed for proper function and settings but it was the responsibility of the floor nurses to ensure the function and setting were accurate daily. An observation of Resident #30's AAM was completed on 5/11/22 at 8:45 AM. The AAM was still set for a weight of 400 pounds but he was not in his room. The Assistant Director of Nursing (ADON) stated Resident #30 was transferred to the hospital yesterday from the wound clinic. An interview was conducted with the MD on 5/11/22 at 9:50 AM. He stated Resident #30 was known to him and had a previous stay in 2021. The MD stated after this most recent hospital admission and subsequent admission to the facility, Resident #30's medical condition had	F 686	weight as needed. Beginning 6/9/22, the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) and assigned special project department head will complete monitoring to ensure compliance of orders for specialty mattresses are correct on EMAR/ETAR and AAM settings are correct per resident weight/manufacture recommendations. The DON, ADON, SDC, and /or the assigned special project department head will observe 6 random residents 5x/week x 4 weeks, then 3x/week x4weeks, then 2x/week x4 weeks to ensure compliance that orders for specialty mattresses are correct on EMAR/ETAR and AAM settings are correct per resident weight/manufacture recommendations. This corrective practice will be applied to any additional residents who receive an order and subsequent AAM to promote skin integrity. Beginning 6/15/22 the Director of Nursing, Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) and/or assigned special project department head will report the findings of the monitoring that orders for specialty mattresses are correct on EMAR/ETAR and AAM settings are correct per resident weight/manufacture recommendations; to the members of the Cardinal Intradisciplinary Team once weekly x3 months to ensure compliance and review for further recommendations and/or follow up as needed for continued compliance.	

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F 686	Continued From page 33 progressively declined. He stated Resident #30's AAM was ordered to be set according to his weight and it was his expectation that the AAM be set according to his actual weight of 182 pounds. Another observation of Resident #30's AAM was completed on 5/11/22 at 4:45 PM. The AAM had been adjusted to the proper weight setting. An interview with the TN was completed on 5/11/22 at 4:50 PM. He stated the MD told him about the incorrect AAM settings earlier and he adjusted the setting in accordance with Resident #30's weight. He stated that all ordered AAM should be set accurately based on the resident's weight. An interview was completed with Nurse #2 on 5/12/22 at 10:10 AM. She stated it was her understanding that all the nurses and TN were responsible for ensuring proper function and setting of any resident ordered an AAM. An interview was completed with the Administrator and the Director of Nursing (DON) on 5/12/22 at 1:15 PM. The DON stated Resident #30's AAM was to be set according to his most recent weight of 182 pounds and not at 400 pounds. 2. Resident #38 was admitted on 11/28/17and recently readmitted on 11/4/21 with cumulative diagnoses neurogenic bladder, contractures, Peripheral Vascular Disease (PVD) and pressure ulcers to his right and left heels. Resident #38 was care planned on 6/24/21 and last revised on 9/17/21 for a pressure ulcer to his	F 686	Beginning the month of July 2022 and continuing for 3 months, the DON or ADON will report the findings of the monitoring that orders for specialty mattresses are correct on EMAR/ETAR and AAM settings are correct per resident weight/manufacture recommendations, monthly Quality Improvement (QI) Committee meeting. The QI Committee will review for further recommendations for follow up as needed or continued compliance to determine the need and/or frequency of the continued QI monitoring to ensure compliance is maintained. Date of completion 06/09/2022.	

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F 686	Continued From page 34	F 686		

left heel. He was care planned on 1/26/21 and last revised 9/17/21 for bilateral arterial ulcers to his lower extremities. Interventions included ensuring the appropriate pressure relieving devices were in place.

His quarterly Minimum Data Assessment dated 4/18/22 indicated he was cognitively intact. He was coded for a urinary catheter one stage 3 pressure ulcer and 3 venous ulcers. His weight was recorded as 240 pounds.

Review of Resident #38's wound ulcer flowsheet dated 4/8/22 indicated his left heel pressure ulcer acquired inhouse (date unknown) was healed as of 4/22/22. He still was receiving wound care for his venous ulcers.

An interview and observation was completed with Resident #38 on 5/9/22 at 12:26 PM. He was lying on an alternating air mattress (AAM) with the weight set at 340 pounds. He stated he had a significant history of pressures to his feet and buttocks along with his venous ulcers.

Review of Resident #38's May 2022 on Physician orders on 5/9/22 did not include an order for a AAM.

An observation and interview was conducted with Nursing Assistant (NA) #6 on 5/10/22 at 10:45 AM. Resident #38's AAM was set for 340 pounds. She stated the aides were not responsible for setting up or checking the AAM for function or settings. She stated to her knowledge, it was either the responsibility of the floor nurses or the TN.

An interview was conducted with the Staff

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Development Coordinator (SDC) on 5/10/22 at 10:47 AM. She stated it was the responsibility of the floor nurses to ensure any AAM's function and setting were accurate.

An interview was conducted with Nurse #1 on 5/10/22 at 11:10 AM. She stated she was not sure who was responsible for ensuring AAM's were functioning properly and the air mattress pump settings were accurate based on the resident's weight. She stated she was under the impression that the TN and Assistant Director of Nursing (ADON) did it since they did wound rounds together weekly.

An interview was conducted with the ADON on 5/10/22 at 11:15 AM. She confirmed she and the TN performed weekly wound assessments. The ADON stated during the wound rounds, the AAM was assessed for proper function and settings but it was the responsibility of the floor nurses to ensure the function and setting were accurate daily.

An observation of wound care was completed on 5/10/22 at 11:20 AM with the TN and the ADON. The area to Resident #38's left heel was healed but noted were 3 venous ulcers to his bilateral lower extremities. The TN and ADON were not observed assessing or adjusting Resident #38's AAM setting.

An observation was completed on 5/11/22 at 8:35 AM. NA #7 was observed assisting Resident #38 with breakfast. His AAM was set at 340 pounds. NA #7 stated she was not aware of who checked the AAM for function and settings. She stated she assumed it was the floor nurses.

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An interview was conducted with the MD on 5/11/22 at 9:50 AM. He stated Resident #38's AAM was ordered to be set according to his weight and it was his expectation that the AAM be set according to his actual weight of 240 pounds.

Another observation was completed on 5/11/22 at 5:05 PM. Resident #38's AAM was still set for a weight of 340 pounds.

An interview was completed with Nurse #2 on 5/12/22 at 10:10 AM. She stated it was her understanding that all the nurses and the TN were responsible for ensuring proper function and setting of any resident ordered an AAM.

An interview was completed with the TN on 5/12/22 at 12:00 PM. He stated the MD informed him of the inaccurate weight setting on Resident #38's AAM but he forgot to correct the setting until late yesterday afternoon. He stated that all ordered AAM's should be set accurately based on the resident's weight.

An interview was completed with the Administrator and the Director of Nursing (DON) on 5/12/22 at 1:15 PM. The DON stated Resident #38's AAM was to be set according to his most recent weight of 240 pounds and not at 340 pounds.

3.Resident #26 was admitted to the facility on 12/21/2017 with diagnosis that included contractures.

The resident's quarterly Minimum Data Set (MDS) dated 2/22/2022 indicated Resident #26 was severely cognitively impaired and nonverbal. The resident was dependent on staff for all activities of daily living including bed mobility,

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dressing, toileting, and personal hygiene during the assessment period. Resident #26 was coded as high risk for pressure injuries and had pressure reducing devices and nonsurgical dressing applied during the assessment period.

Resident #26's comprehensive care plan dated 3/9/2022 contained a focus for risk of skin breakdown or pressure injuries. Interventions included ensuring appropriate pressure reducing devices and air mattress were in place.

The resident's active orders revealed a physician's order for air mattress dated 3/27/2022 with no end date. The order was entered by staff development coordinator (SDC).

On 5/10/2022 at 3:43 PM an observation of wound care by the treatment nurse, with the Assistant Director of Nursing (ADON) present, was conducted. Resident #26 was observed to have blanchable redness to bilateral buttocks and scrotum. When writer asked the treatment nurse to characterize the wound, the treatment nurse stated it was a stage 1. Additionally, the resident was observed to have broken skin in a linear pattern on his right buttock. When asked about the mattress, both the ADON and the treatment nurse stated the resident was not on an air mattress, he was on a wing mattress.

On 5/11/2022 at 11:40 AM an interview was conducted with the treatment nurse. He reviewed Resident #26's active order set and stated he did not know the resident had an order for air mattress or why he had an order for an air mattress.

An interview with the SDC on 5/12/2022 at 11:42

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F 686	Continued From page 38 AM. She stated the facility recently transitioned from paper medical records to electronic medical records. When she transcribed Resident #26's active orders form paper to electronic format, the resident had an order for an air mattress. Therefore, she carried the order over. She did not know if Resident #26 was on an air mattress.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to apply splints as ordered for contracture management (Resident #38). This was for 1 of 1 residents reviewed for range of motion (ROM). The findings included: Resident #38 was admitted on 11/28/17 and most	F 688	On 5/9/22, 5/10, 5/11, and 5/12/22 during a recertification and complaint survey at Richmond Pines Healthcare and Rehabilitation Center, the survey team observed Resident #38 did not have splint applied per therapy recommendations. Resident #38 continues to reside at the	6/9/22

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F 688	Continued From page 39 recently readmitted on 11/4/21 with cumulative diagnoses neurogenic bladder and contractures. Review of Resident #38's revised care plan dated 12/1/21 indicted he required assistance to restore or maintain his maximum potential and risk for worsening of his present contractures. Interventions included the application of a left elbow splint 6 days a week for 4 hours each day. His quarterly Minimum Data Assessment dated 4/18/22 indicated he was cognitively intact and coded for impairment to his bilateral upper and lower extremities. Review of Resident #38's April and May 2022 Physician orders did not include any orders for splinting to his contractures. Review of Resident #38's restorative documentation for April and May 2022 indicated he was to receive restorative nursing for passive range of motion (PROM) to his bilateral shoulders, left elbow, right elbow, bilateral wrist and bilateral fingers on each hand 5 times each week. Resident #38 was also to receive restorative nursing for the application of a left elbow splint and bilateral hand splints for 4 hours a day for 6 times a week. An interview and observation was completed with Resident #38 on 5/9/22 at 12:26 PM. He had bilateral hand contractures and a left elbow contracture. There was a folded pillow case placed in the crease of his left elbow contracture and nothing to his bilateral hands. He stated at one time recently, the staff were applying his bilateral hand splints and his left elbow splint but it had not been done in a while.	F 688	facility and continues to require the use of bilateral hand splints and left elbow splint. On 5/11/22 Resident #38 bilateral hand splints and left elbow splint was applied at 1459 by Certified Nursing Assistant (CNA) assigned to care for Resident #38 as resident tolerated. On 5/12/22 Resident #38 bilateral hand splints and left elbow splint was applied at 1459 by Certified Nursing Assistant assigned to care for Resident #38 as resident tolerated. Root Cause: Restorative Aide was on a resident assignment and no other nursing/therapy staff applied Resident #38 bilateral hand splints and left elbow to increase/prevent decrease in range of motion/mobility. All residents have the potential to be affected by this alleged deficient practice. On 6/1/22, the Assistant Director of Nursing (ADON) and Therapy Director completed 100% audit of residents requiring splints/braces to increase/prevent decrease in Range of Motion (ROM)/mobility. On 6/2/22, splints/braces per Licensed Provider orders and/or Therapy recommendations were added to EMAR for nurses to ensure the residents requiring splints/braces to increase/prevent decrease in Range of Motion (ROM)/mobility are in place as resident tolerates. To protect current and like residents, on 6/2/22, the Assistant Director of Nursing	

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F 688	Continued From page 40 An observation was completed on 5/10/22 at 10:51 AM of Resident #38's. There was a folded pillow case placed in the crease of his left elbow contracture and nothing to his bilateral hands. An interview was conducted on 5/11/22 at 8:20 AM with Nursing Assistant (NA) #6 stated she was assigned Resident #38 on 5/9/22 and 5/10/22. She stated she did not apply Resident #38's splint because he was on the restorative nursing caseload. An observation was completed on 5/12/22 at 9:40 AM of Resident #38. There were no observed splints in use for his left elbow and bilateral hand contractures. An interview was completed on 5/12/22 at 9:50 AM with the Assistant Director of Nursing (ADON). She stated she was over the restorative program. The ADON was questioned as to why no splints were observed in use on 5/9/22, 5/10/22, 5/11/22 and 5/12/22, she was unable to provide an answer. An interview was completed on 5/12/22 at 11:45 AM with the Restorative Aide (RA). She stated she has had to work the floor all week and that was why Resident #38 did not receive any PROM or splinting. She stated the ADON was aware but the Scheduler continued to assign her to work on the floor and nobody assisted her with splinting when she was assigned to work the floor. An interview was completed on 5/12/22 at 12:03 PM with the facility scheduler. She stated the RA was only scheduled to work the floor today. She stated anytime she needed to pull the RA to work	F 688	(ADON) and Therapy Director began cross-training additional CNAs in applying splints/braces to increase/prevent decrease in Range of Motion (ROM)/mobility as resident tolerates. The Staff Development Coordinator (SDC), Director of Nursing (DON), Assistant Director of Nursing (ADON), and Regional Clinical Nurse Consultant will begin education to facility department heads and facility/agency nursing staff on 6/1/22 on ensuring splints/braces are being applied as per Licensed Provider orders and/or Therapy recommendations. This education will be completed on 6/8/22. On 6/1/22, the SDC added this education to the new hire packet and agency/contract staff packet. On 6/9/22, the Staff Development Coordinator will mail education to any Contracted Agency/Facility Nursing Staff that had not completed education of on ensuring splints/braces are being applied as per Licensed Provider orders and/or Therapy recommendations. After 6/8/22, no Contracted Agency/Facility Nursing Staff will be allowed to work until education on ensuring splints/braces are being applied as per Licensed Provider orders and/or Therapy recommendations. Beginning 6/9/22 22 the Assistant Director of Nursing (ADON), Therapy Director and/or assigned special project therapy staff member will complete monitoring to	

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F 688	Continued From page 41 the floor she always notified either the ADON or the Director of Nursing (DON). An interview was completed with the Administrator and the DON on 5/12/22 at 1:15 PM. The DON stated she expected the RA and ADON to ensure Resident #38's splints were applied as ordered.	F 688	ensure compliance of ensuring splints/braces are being applied as per Licensed Provider orders and/or Therapy recommendations. the Assistant Director of Nursing (ADON), Therapy Director and/or assigned special project therapy staff member will observe 6 random residents 5x/week x 4 weeks, then 3x/week x4,weeks, then 2x/week x4 weeks to ensure compliance of ensuring splints/braces are being applied as per Licensed Provider orders and/or Therapy recommendations Beginning 6/15/22 the Assistant Director of Nursing (ADON), Therapy Director will report the findings of the monitoring of splints/braces are being applied as per Licensed Provider orders and/or Therapy recommendations to the members of the Cardinal Intradisciplinary Team once weekly x3 months to ensure compliance and review for further recommendations and/or follow up as needed for continued compliance. Beginning the month of July 2022 and continuing for 3 months, ADON and/or Therapy Director will report the findings of the monitoring that of ensuring splints/braces are being applied as per Licensed Provider orders and/or Therapy recommendations monthly Quality Improvement (QI) Committee meeting. The QI Committee will review for further recommendations for follow up as needed or continued compliance to determine the need and/or frequency of the continued QI monitoring to ensure compliance is	

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F 688	Continued From page 42	F 688	maintained. Date of completion 06/09/2022.	
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690		6/9/22

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F 690	Continued From page 43 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff, resident and Medical Director (MD) interviews and record review, the facility failed to ensure Physician orders were obtained and implemented for the care and assessment of residents with indwelling urinary catheters (Resident #30, Resident #38 and Resident #74). The facility also failed to place a securement device for an indwelling urinary catheter (Resident #30). This was for 3 of 6 residents reviewed for urinary catheters. The findings included: 1. Resident #30 was admitted 3/3/22 cumulative diagnoses of a Urinary Tract Infection (UTI) and urinary retention. His admission Minimum Data Set (MDS) dated 3/10/22 indicated he was cognitively intact, required extensive staff assistance with his activities of daily living (ADLs) and was coded for a urinary catheter. Resident #30's care plan last revised 4/1/22 read he had an altered pattern of urinary elimination with an indwelling urinary catheter. Interventions included catheter care per the facility protocol, change the catheter per MD orders and/or facility protocol, maintain an unobstructed urine flow and ensure the urinary was below the level of the bladder. There was no intervention of a securement device. Review of Resident #30's weekly electronic urinary catheter assessments from admission 3/4/22 to 5/5/22 all completed by the facility	F 690	On 5/9/22, during a recertification and complaint survey at Richmond Pines Healthcare and Rehabilitation Center, the survey team observed Resident #30, Resident #38, and Resident #74 did not have Licensed Provider orders and/or facility protocols in place for care and assessment of indwelling urinary catheters. 1. Resident #30 no longer resides at the facility. 2. Resident #38 continues to reside at the facility and continues to require an indwelling urinary catheter. 3. Resident #74 continues to reside at the facility and continues to require an indwelling urinary catheter. On 5/10/22 Facility Management Nurses obtained and implemented orders on the EMAR/ETAR for care and assessment of indwelling urinary catheter for Resident #38. On 5/10/22 Facility Management Nurses obtained and implemented orders on the EMAR/ETAR for care and assessment of indwelling urinary catheter for Resident #38. Root Cause: Nurses did not obtain or implement Licensed Provider orders and/or facility protocols for care and assessment of indwelling urinary catheters.	

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F 690	Continued From page 44 Treatment Nurse (TN) and once by the Assistant Director of Nursing (ADON) did not include any documentation regarding the appearance of the catheter insertion site. Review of Resident #30's May 2022 Physician orders did not include any orders for a urinary catheter, catheter changes, assessment or the maintenance of his urinary catheter. There were also no orders to follow the facility protocol for urinary catheters. Review of Resident #30's March, April and May 2022 Treatment Administration Records (TAR) did not include any documented evidence of urinary catheter care, assessment or maintenance. Review of a nursing note dated 5/9/22 at 11:05 PM read Nurse #9 noted some blood around his catheter insertion site and she notified the MD. There were no new orders. An interview and observation were conducted with Resident #30 on 5/9/22 at 11:46 AM. He stated his urinary catheter insertion site was "stinging" and the tube was tugging on the insertion site. He pulled back his top sheet to reveal there was no securement device attached to either thigh. He stated when he was first admitted, the staff put some sort of device that held his urinary catheter in place. He stated they stopped using it several weeks ago. An observation of Resident #30's urinary catheter insertion site was completed on 5/10/22 at 10:35 AM with the TN. Resident #30 stated his urinary catheter was hurting, pulling, tugging and the catheter insertion site was stinging. The TN	F 690	All residents requiring and indwelling catheter have the potential to be affected by this alleged deficient practice. All corrective practices applied to current residents with catheters will be equally implemented and audited for corrective orders and protocols. On 5/10/22 the Assistant Director of Nursing (ADON), Treatment Nurse, and Quality Assurance & Improvement (QA&I) Nurse completed 100% audit of residents requiring indwelling urinary catheters. On 5/10/22 the Assistant Director of Nursing (ADON), Treatment Nurse, and Quality Assurance & Improvement Nurse obtained and implemented orders for residents requiring indwelling urinary catheter care and assessment. The Staff Development Coordinator (SDC), Director of Nursing (DON), Assistant Director of Nursing (ADON), and Regional Clinical Nurse Consultant will begin education to facility department heads and facility/agency nursing staff on 6/1/22 on ensuring obtaining and implementing orders for residents requiring indwelling urinary catheter care and assessment. This education also included notifying licensed provider of changes to the indwelling urinary catheter site for additional orders and ensuring a securement device is in place to prevent pulling or tugging that may lead to trauma. This education will be completed on 6/8/22. On 6/1/22 the SDC added this education	

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F 690	Continued From page 45	F 690		

pulled back the top sheet and noted no securement device. He stated the stat locks (a urinary catheter stabilization device used for securing a catheter in place to prevent pulling and trauma) had been on back order for a couple of months. The TN stated there should be some sort of securement in place even if the stat locks were on back order. He stated it could be stabilized with tape or a leg strap. The TN removed Resident #30's brief to reveal dried blood to the inside of his brief. There was also observed of dark red blood at the catheter insertion site. The TN stated he was not aware of the observed trauma. He stated he would clean the area and ensure a securement device was placed. The TN stated he was under the impression there was a urinary catheter protocol on his Physician orders. The TN stated he was not aware of where to locate the facility's urinary catheter protocol.

An interview was conducted with Nursing Assistant (NA) #6 on 5/10/22 at 10:45 AM. She stated the aides were allowed the clean around the urinary catheter insertions sites but not allowed to place a securement device on Resident #30's leg. She stated the TN, or the floor nurses did that. NA #6 stated she did not notice any evidence of trauma or blood during his ADL care on 5/9/22.

An interview was conducted with Nurse #1 on 5/10/22 at 11:10 AM. She stated it was her understanding that the TN changed the urinary stat locks weekly. She stated she was not aware that Resident #30 did not have a securement device in place or about the observed trauma at the urinary catheter insertion site.

An interview was conducted with the Assistant

to the new hire packet and agency/contract staff packet.
On 6/9/22 the Staff Development Coordinator will mail education to any Contracted Agency/Facility Nursing Staff that had not completed education of on ensuring obtaining and implementing orders for residents requiring indwelling urinary catheter care, assessment, and notifying licensed provider of changes to the indwelling urinary catheter site ensuring a securement device is in place to prevent pulling or tugging that may lead to trauma.

After 6/8/22, no Contracted Agency/Facility Nursing Staff will be allowed to work until education on ensuring obtaining and implementing orders for residents requiring indwelling urinary catheter care and assessment. This education also included notifying licensed provider of changes to the indwelling urinary catheter site for additional orders and ensuring a securement device is in place to prevent pulling or tugging that may lead to trauma.

Beginning 6/9/22 22 the SDC, DON, ADON, Treatment Nurse, QA&I Nurse, and/or assigned special project department head will complete monitoring to ensure compliance of obtaining and implementing orders for residents requiring indwelling urinary catheter care, assessment, securement device is in place, and notifying licensed provider of changes to the indwelling urinary catheter site. the SDC, DON, ADON, Treatment

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F 690	Continued From page 46 Director of nursing (ADON) on 5/10/22 at 11:15 AM. She stated the and the TN performed weekly wound rounds together. She stated normally if the resident had a wound and a urinary catheter, the catheter was part of the weekly assessment as well. An interview was completed on 5/10/22 at 4:00 PM, Nurse #9 stated she observed blood in Resident #30's brief yesterday and she notified the MD but there were no orders were given. Nurse #9 stated she could not recall if there was a urinary securement device in place on 5/10/22. An interview was conducted with the MD on 5/11/22 at 9:50 AM. He stated he was under the impression that the facility had a protocol for the care of residents with urinary catheters and was not aware there were no orders for the care and assessment of Resident #30's urinary catheter. He stated Resident #30's catheter should always have a securement device in place to prevent trauma or accidental removal of his urinary catheter. The MD stated the nurses, or the TN should have obtained monthly Physician orders for Resident #30's urinary catheter, assessed and cleaned his urinary catheter insertion site daily. An interview was completed with the Administrator and the Director of Nursing (DON) on 5/12/22 at 1:15 PM. The DON stated there should be Physician orders for his urinary catheter, be secured and assessed daily. 2. Resident #38 was admitted on 11/28/17and most recently readmitted on 11/4/21 with cumulative diagnoses neurogenic bladder and contractures.	F 690	Nurse, QA&I Nurse, and/or assigned special project department head will observe 6 random residents 5x/week x 4 weeks, then 3x/week x4weeks, then 2x/week x4 weeks ensure compliance of obtaining and implementing orders for residents requiring indwelling urinary catheter care, assessment, securement device is in place, and notifying licensed provider of changes to the indwelling urinary catheter site Beginning 6/15/22 ADON, DON, and/or QA&I nurse will report the findings of the monitoring: obtaining and implementing orders for residents requiring indwelling urinary catheter care, assessment, securement device is in place, and notifying licensed provider of changes to the indwelling urinary catheter site to the members of the Cardinal Intradisciplinary Team once weekly x3 months to ensure compliance and review for further recommendations and/or follow up as needed for continued compliance. Beginning the month of July 2022 and continuing for 3 months, ADON, DON, and/or QA&I nurse will report the findings of the monitoring that of obtaining and implementing orders for residents requiring indwelling urinary catheter care, assessment, securement device is in place, and notifying licensed provider of changes to the indwelling urinary catheter site monthly Quality Improvement (QI) Committee meeting. The QI Committee will review for further recommendations for follow up as needed or continued	

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Resident #38's care plan last revised 9/17/21 read he had an altered pattern of urinary elimination with a suprapubic urinary catheter (a catheter used to drain urine from the bladder). Interventions included catheter care per the facility protocol, change the catheter per MD orders and/or facility protocol, maintain unobstructed urine flow, ensure the urinary was below the level of the bladder and the catheter secured with an anchoring device.

His quarterly Minimum Data Assessment dated 4/18/22 indicated he was cognitively intact, coded for a urinary catheter and total assistance with all his activities of daily living (ADLs).

Review of Resident #38's May 2022 Physician orders did not include any orders for a suprapubic catheter, catheter changes, assessment or maintenance of his urinary catheter. There were also no orders for the facility protocol for urinary catheters.

Review of Resident #38's April and May 2022 Treatment Administration Record (TAR) did not include any documented evidence of urinary catheter care, assessment or maintenance.

Review of Resident #38's nursing notes dated 1/28/22, 2/27/22, 3/16/22, 3/23/22, 4/9/22 and 4/20/22 all contained documentation regarding his suprapubic catheter sliding out or leaking.

An interview and observation were completed with Resident #38 on 5/9/22 at 12:26 PM. He stated he was worried about the hole in his stomach. He confirmed he was describing his suprapubic insertion site.

compliance to determine the need and/or frequency of the continued QI monitoring to ensure compliance is maintained.

Date of completion 06/09/2022.

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An observation and interview were conducted with Nursing Assistant (NA) #6 on 5/10/22 at 10:45 AM. She was in the process of providing Resident #38's morning ADLs. The aide lifted his abdominal fold to reveal a suprapubic insertion site with an open area to the right of the insertion site with bright red blood. His securement device was in place. NA #6 stated the area did not appear that way on 5/9/22 because she would have reported it to the nurse.

An observation and interview were conducted with the Staff Development Coordinator (SDC) on 5/10/22 at 10:47 AM. She stated she was not aware Resident #38's catheter insertion site looked the way it did. The SDC stated the floor nurses and the aides provided catheter care but the Treatment (TN) and the Assistant Director of Nursing (ADON) assessed the catheter insertion sites weekly.

An interview was conducted with Nurse #1 on 5/10/22 at 11:10 AM. She stated she thought the floor nurses, or the TN assessed and cleaned Resident #38's suprapubic insertion site daily. She stated she had not completed care or assessment of Resident #38's catheter on 5/9/22 or 5/10/22 and she was not aware of bleeding at the insertion site.

An observation and interview were completed on 5/10/22 at 11:20 AM with the TN and the ADON. Both assessed Resident #38's suprapubic insertion site and stated the area did not appear that way when assessed last week. The TN proceeded to clean the area with gauze with fresh blood observed. The ADON stated she would notify the MD of the appearance of Resident #38's suprapubic catheter insertion site. The TN

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stated he was under the impression there was a suprapubic catheter protocol on his Physician orders. The TN stated he was not aware of where to locate the facility's suprapubic catheter protocol.

An interview was conducted with the MD on 5/11/22 at 9:50 AM. He stated he was under the impression that the facility had a protocol for the care of residents with suprapubic catheters and was not aware that there were no orders for the care and assessment of Resident #38's suprapubic catheter. He stated the ADON contacted him on 5/10/22 and notified of the appearance of his catheter insertion site. He stated he gave new orders to clean the area daily. The MD stated the nurses, or the TN should have obtained monthly Physician orders for his suprapubic catheter, assessed and cleaned his suprapubic site daily.

Review of Resident #38's Physician orders included an order dated 5/11/22 for daily and as needed cleaning of his suprapubic catheter site using normal saline and gauze, pat dry with gauze, cover site the with a T-Sponge (a precut, snug fit sponge designed to wick moisture away from the catheter site) and secure the sponge with tape for wound healing.

An interview was completed with the Administrator and the Director of Nursing (DON) on 5/12/22 at 1:15 PM. The DON stated The DON stated there should be Physician orders for Resident #38's suprapubic and assessed daily.
3. Resident #74 was admitted on 9/30/2019 with diagnosis that included acute kidney failure. Resident #74's quarterly Minimum Data Set (MDs) dated 4/6/2022 and indicated the resident

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was mildly cognitively impaired, required assistance with activities of daily living (ADL), and had an indwelling urinary catheter.

Resident #74's comprehensive care plan, last revised on 3/16/2022, included a focus for altered pattern or urinary elimination related to indwelling urinary catheter. Interventions included catheter care per physician's order or the facility protocol, catheter changes per MD orders and/or facility protocol, maintain unobstructed urine flow, ensure the urinary was below the level of the bladder and the catheter secured with an anchoring device.

Resident #74 had a physician's order dated 4/22/2022 for reinsertion of urinary catheter for wound healing. The order was entered by the ADON.

Resident #74's May 2022 Physician orders did not include orders for changes, assessments, or maintenance of his urinary catheter.

The facility's protocol for indwelling urinary catheters did not address care and maintenance of a urinary catheters.

Resident #74's April and May 2022 Treatment Administration Record (TAR) did not include any documented evidence of urinary catheter care, assessment or maintenance.

An interview was conducted with Resident #74 on 5/11/2022 at 2:05 PM. She stated the staff cleaned her urinary catheter every shift.

An interview was conducted with the ADON on 05/11/2022 at 2:48 PM. She stated she did put in

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F 690	Continued From page 51 the order for Resident #74's indwelling urinary catheter. She further stated the urinary catheter was placed for wound healing. The ADON stated she should have put in catheter care orders but she did not. On 5/11/2022 at 4:11 PM an interview was conducted with Nurse #9. She stated she was assigned to Resident #74 and she provided urinary catheter care to the resident every shift. Nurse #9 reviewed Resident #74's medical record and stated she could not find urinary catheter care orders for the resident. An interview was conducted with the MD on 5/11/22 at 9:50 AM. He stated he thought the facility had a protocol for the care of residents with indwelling urinary catheters. He further stated he was not aware there were no orders for the care and assessment of Resident #74's indwelling urinary catheter. An interview was completed with the Administrator and the Director of Nursing (DON) on 5/12/22 at 1:15 PM. The DON stated there should be Physician orders for daily care and maintenance of Resident #74's urinary catheter.	F 690		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by:	F 694		6/9/22

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F 694	Continued From page 52 Based on observations, resident, staff, Vascular Nurse and Medical Director (MD) interviews, the facility failed to provide a dressing change to a Peripherally Inserted Central Catheter (PICC) line as ordered. This was for 1 (Resident #73) of 1 residents reviewed for infections. The findings included Resident #73 was admitted on 2/14/19 and readmitted 4/28/22 with a diagnosis of Urosepsis. Her quarterly Minimum Data Set dated 4/6/22 indicated she was cognitively intact and she exhibited no behaviors. Review of Resident #73's hospital discharge summary dated 4/28/22 read a PICC line was placed on 4/27/22 and she was to continue to receive an Intravenous (IV) antibiotic for another 36 doses. Review of Resident #73's readmission Physician orders dated 4/28/22 read she was to receive an IV antibiotic every 6 hours for 9 days. The completion date of her IV antibiotic was 5/7/22. Resident #73 was care planned on 5/3/22 for an actual urinary tract infection. Interventions included observation of the PICC line for signs of infection and notify the MD, PICC line site care, flushes to the PICC line per the facility protocol or as ordered by the Physician. The Administrator provided a copy of the facility's PICC Reference Sheet dated June 2020 from a procedure manual. The transparent dressing should be changed at least every 7 days or immediately when the dressing appeared compromised.	F 694	team observed Resident #73 did not provide dressing changes and care for Peripherally Inserted Central Catheter (PICC) per licensed provider orders and/or facility protocol. Resident #73 continues to reside at the facility and no longer requires the use of a PICC. On 5/10/22 Resident #73 dressing change was completed by Staff Development Coordinator (SDC). On 5/11/22 SDC obtained an order from licensed provider to remove the PICC line due to no longer needed. On 5/11/22 Vascular Wellness nurse in the facility to remove PICC line per licensed provider order. Root Cause: Nursing staff did not obtain and/or implement PICC line orders from a licensed provider and/or facility protocol for dressing changes, care, and assessment. All residents with new or existing PICC lines have the potential to be affected by this alleged deficient practice. The corrective actions set forth will be utilized for any residents found to be in a similar situation as Resident #73. On 5/10/22, Staff Development Coordinator (SDC), began 100% audit of residents with PICC lines to ensure Residents with PICC lines had orders from a licensed provider and/or facility protocol for dressing changes, care, and assessment. This audit also included	

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F 694	Continued From page 53 Review of Resident #73's May 2022 Physician orders included an order dated 5/3/22 provide PICC line site care per the facility's protocol or as ordered by the Physician. Another Physician order was dated 5/11/22 to pull out the PICC line. Review of Resident #73's April and May 2022 Medication Administration Records and Treatment Administration Records did not include any documented evidence of Resident #73's dressing change to her PICC line for 13 days. An interview and observation was completed on 5/9/22 at 11:06 AM with Resident #73. The PICC was observed to her right upper arm. There was a dressing in place that appeared rolled up around the edges but still intact at the insertion site. Resident #73 stated she just completed her IV antibiotics and she thought the PICC line dressing was the same one she was discharged from the hospital with. An observation was completed on 5/10/22 at 10:45 AM. The same dressing was still in place to Resident #73's PICC line. An interview was conducted with the Assistant Director of nursing (ADON) on 5/10/22 at 11:15 AM. She stated it was the facility's protocol to change the dressing to a PICC line every 7 days. An observation and interview was completed on 5/11/22 8:50 AM with the Vascular Nurse (VN). She stated she was there to remove Resident #73's PICC line. The PICC line dressing had been changed on 5/10/22 by the Staff Development Coordinator (SDC). She stated she was not familiar with the facility's policy on PICC lines. The VN stated the dressing changes to the	F 694	checking care plans to ensure residents with PICC lines had a care plan to reflect PICC line care. This audit was completed on 5/18/22. The Staff Development Coordinator (SDC), Director of Nursing (DON), Assistant Director of Nursing (ADON), and Regional Clinical Nurse Consultant will begin education on 6/1/22 on ensuring residents with PICC lines have orders from a licensed provider and/or facility protocol for dressing changes, care, assessment, and care plan. This education will be completed on 6/8/22. On 6/1/22 the SDC added this education to the new hire packet and agency/contract staff packet. On 6/9/22 the Staff Development Coordinator will mail education to any Contracted Agency/Facility Nursing Staff that had not completed education of ensuring residents with PICC lines have orders from a licensed provider and/or facility protocol for dressing changes, care, assessment, and care plan After 6/8/22, no Contracted Agency/Facility Nursing Staff will be allowed to work until education on ensuring residents with PICC lines have orders from a licensed provider and/or facility protocol for dressing changes, care, assessment, and care plan Beginning 6/9/22 the Director of Nursing, Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) and assigned special project department head	

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F 694	Continued From page 54 PICC line site should be completed every 7 days and as needed. An interview was completed on 5/11/22 at 10:23 AM with the SDC. She stated on 5/10/22 she noticed Resident #73's PICC line dressing had not been changed since her readmission so she did it. The SDC stated PICC line dressing changes were done every 7 days and as needed. She stated she was unsure why Resident #73's PICC line dressing was not changed 7 days after her readmission on 4/28/22. An interview was completed on 5/11/22 at 9:50 AM with the MD. He stated it was his expectation that Resident #73's PICC line dressing to be changed every 7 days. An interview was completed with the Administrator and the DON on 5/12/22 at 1:15 PM. The DON stated Resident #73's PICC line dressing should have been changed last week on day 7 prior to 5/10/22.	F 694	will complete monitoring to ensure compliance of ensuring residents with PICC lines have orders from a licensed provider and/or facility protocol for dressing changes, care, assessment, and care plan. The Director of Nursing, the Unit Manager(s), and /or the assigned special project department head will observe 6 random residents 5x/week x 4 weeks, then 3x/week x4weeks, then 2x/week x4 weeks to ensure compliance that residents with PICC lines have orders from a licensed provider and/or facility protocol for dressing changes, care, assessment, and care plan Beginning 6/15/22 the Director of Nursing, Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) and/or assigned special project department head will report the findings of the monitoring residents with PICC lines have orders from a licensed provider and/or facility protocol for dressing changes, care, assessment, and care plan, to the members of the Cardinal Intradisciplinary Team once weekly x3 months to ensure compliance and review for further recommendations and/or follow up as needed for continued compliance. Beginning the month of July 2022 and continuing for 3 months, the DON or ADON will report the findings of the monitoring that residents with PICC lines have orders from a licensed provider and/or facility protocol for dressing changes, care, assessment, and care plan monthly Quality Improvement (QI)	

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F 694	Continued From page 55	F 694	Committee meeting. The QI Committee will review for further recommendations for follow up as needed or continued compliance to determine the need and/or frequency of the continued QI monitoring to ensure compliance is maintained. Date of completion 06/09/2022.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff and Medical Director (MD) interviews and record review, the facility failed to administer continuous oxygen at the prescribed rate (Resident #73 and Resident #80). This was for 2 of 3 residents reviewed for respiratory care. The findings included: 1. Resident #73 was admitted on 2/14/19 and readmitted 4/28/22 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). Her quarterly Minimum Data Set dated 4/6/22 indicated she was coded for the use of oxygen. Resident #73 was care planned for ineffective breathing pattern related to COPD. This care plan	F 695	On 5/9/22, during a recertification and complaint survey at Richmond Pines Healthcare and Rehabilitation Center, the survey team observed Resident #73, and Resident #80 were not getting continuous oxygen (O2) therapy per the prescribed rate as per licensed provider orders. 1. Resident #73 continues to reside at the facility and continues to require continuous O2 at 2L/Min via nasal cannula. 2. Resident #80 continues to reside at the facility and continues to require continuous O2 at 2L/Min via nasal cannula.	6/9/22

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F 695	Continued From page 56 was last revised on 3/11/22 and included the intervention of oxygen therapy 2L/Min via nasal cannula as ordered. Review of Resident #73's readmission Physician orders dated 4/28/22 included an order for continuous oxygen at 2 liter per minute (L/Min) due to COPD. This order was dated 10/12/21. Review of Resident #73's April 2022 Medication Administration Records (MAR) included documentation that the nurses were assessing Resident #73's oxygen rate every shift prior to her hospital transfer on 4/24/22 but it was not continued after her readmission on 4/28/22. Review of Resident #73's May 2022 MAR did not include any documentation regarding her prescribed oxygen. An interview and observation was completed on 5/9/22 at 11:06 AM with Resident #73. She was wearing her oxygen with the concentrator rate set at 3.5 L/Min. Resident #73 stated she required oxygen at all times due to her COPD. An observation was completed on 5/10/22 at 10:45 AM. Resident #73 was wearing her oxygen with the concentrator rate set at 3.5 L/Min. An interview was completed with the Assistant Director of nursing (ADON) on 5/10/22 at 11:15 AM. She stated the floor nurses check the oxygen concentrators settings every shift on the residents prescribed continuous oxygen. An observation was completed on 5/11/22 8:50 AM. Resident #73 was wearing her oxygen with the concentrator set at 4.5 L/Min.	F 695	On 5/12/22, Resident #73 O2 flow rate was adjusted to 2L/Min via nasal cannula. On 5/27/22 Resident #73 EMAR was corrected to reflect continuous O2 at 2L/Min via nasal cannula per licensed provider clarification. On 5/12/22, Resident # 80 flow O2 flow rate was adjusted to 2L/Min via nasal cannula. Root Cause: Nursing staff did check O2 flow rate every shift to ensure O2 was being administered per licensed provider order. Nurse did not transcribe O2 order for continuous O2 on resident #73 and no other nurse initiated or implemented Resident #73 continuous O2 order. All residents requiring O2 have the potential to be affected by this alleged deficient practice. The corrective actions set forth will be utilized for any residents found to be in a similar situation as Resident #73 and #80. On 5/18/22 Assistant Director of Nursing completed 100% audit of residents to ensure any resident requiring O2 had accurate orders and flow rates transcribed to the EMAR and concentrators/O2 cylinders regulators reflect the ordered flow rate. In addition, the audit included accurate O2 care plan and interventions. This audit was completed 5/27/22. The Staff Development Coordinator (SDC), Director of Nursing (DON), Assistant Director of Nursing (ADON), and	

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F 695	Continued From page 57 An interview was completed on 5/11/22 at 9:00 AM with Nurse #3. She stated Resident #73 was prescribed continuous oxygen and she was very compliant about wearing it. Nurse #3 stated the nurses check Resident #73's oxygen concentrator setting every shift to make sure the setting was at the prescribed rate. An interview was completed on 5/11/22 at 9:50 AM with the MD. He stated it was his expectation that Resident #73's continuous oxygen be administrated at the ordered rate of 2 L/Min unless otherwise indicated. An interview was completed with the Administrator and the DON on 5/12/22 at 1:15 PM. The DON stated Resident #73's oxygen should be administered at the ordered rate of 2 L/Min. 2.Resident #80 was admitted on 12/21/2015 with diagnoses that included chronic obstructive pulmonary disease (COPD). Resident #80's quarterly Minimum Data Set (MDS) dated 4/14/2022 indicated the resident was cognitively intact, was dependent upon staff for assistance with activities of daily living (ADL) and received oxygen during the assessment period. The resident's comprehensive care plan was last updated on 4/27/2022 and contained a focus for potential for ineffective breathing patter related to COPD, oxygen dependence, and respiratory failure. Interventions included administer oxygen at 2 liters per minute via nasal cannula. Resident #80's medical record contained a	F 695	Regional Clinical Nurse Consultant will begin education on 6/1/22 on ensuring resident requiring O2 had accurate orders and flow rates transcribed to the EMAR per licensed provider orders, concentrators/O2 cylinders regulators reflect the ordered flow rate, O2 care and assessment per facility protocol, and accurate O2 care plan and interventions. This education will be completed on 6/8/22. On 6/1/22 the SDC added this education to the new hire packet and agency/contract staff packet. On 6/9/22 the Staff Development Coordinator will mail education to any Contracted Agency/Facility Nursing Staff that had not completed education ensuring resident requiring O2 had accurate orders and flow rates transcribed to the EMAR per licensed provider orders, concentrators/O2 cylinders regulators reflect the ordered flow rate, O2 care and assessment per facility protocol, and accurate O2 care plan and interventions. After 6/8/22, no Contracted Agency/Facility Nursing Staff will be allowed to work until education on ensuring resident requiring O2 had accurate orders and flow rates transcribed to the EMAR per licensed provider orders, concentrators/O2 cylinders regulators reflect the ordered flow rate, O2 care and assessment per facility protocol, and accurate O2 care plan and interventions Beginning 6/9/22 the Director of Nursing, Assistant Director of Nursing (ADON),	

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F 695	Continued From page 58 physician's order for oxygen at 2 liters per minute continuous for cyanosis (blueish color to nail beds and membranes) and dyspnea (difficult or labored breathing). The start date for the order was 3/9/2022 and the order was entered in the electronic medical record by the SDC. On 5/9/2022 Resident #80 was observed lying in bed, alert, oriented, and using an electronic device. She was observed to be on 4 liters of oxygen via nasal cannula. On 5/10/2022 at 1:50 PM resident #80 was observed resting in bed with her eyes closed. The oxygen concentrator was set on 4 liters per minute and being administered via nasal cannula. An interview was conducted with Medication Aide #2 on 5/10/2022 at 1:54 PM. She stated she was assigned to Resident #80. She reviewed the resident's active order for oxygen and stated she thought the resident was on 4 liters, not 2 liters, per minute of oxygen continuously. She had not noticed the order was for 2 liters per minute. An interview was conducted with the SDC on 5/12/2022 at 11:42 AM. She did not recall a written order for oxygen at 4 liter per minute for Resident #80. On 5/12/2022 at 1:15 PM and interview was conducted with the Director of Nursing (DON). She stated she expected oxygen to be accurate and oxygen administered per physician's order.	F 695	Staff Development Coordinator (SDC) and assigned special project department head will complete monitoring to ensure compliance of ensuring resident requiring O2 had accurate orders and flow rates transcribed to the EMAR per licensed provider orders, concentrators/O2 cylinders regulators reflect the ordered flow rate, O2 care and assessment per facility protocol, and accurate O2 care plan and interventions The Director of Nursing, the Unit Manager(s), and /or the assigned special project department head will observe 6 random residents 5x/week x 4 weeks, then 3x/week x4weeks, then 2x/week x4 weeks to ensure compliance that ensuring resident requiring O2 had accurate orders and flow rates transcribed to the EMAR per licensed provider orders, concentrators/O2 cylinders regulators reflect the ordered flow rate, O2 care and assessment per facility protocol, and accurate O2 care plan and interventions Beginning 6/15/22 the Director of Nursing, Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) and/or assigned special project department head will report the findings of resident requiring O2 had accurate orders and flow rates transcribed to the EMAR per licensed provider orders, concentrators/O2 cylinders regulators reflect the ordered flow rate, O2 care and assessment per facility protocol, and accurate O2 care plan and interventions, to the members of the Cardinal Intradisciplinary Team once weekly x3 months to ensure compliance and review	

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F 695	Continued From page 59	F 695	for further recommendations and/or follow up as needed for continued compliance. Beginning the month of July 2022 and continuing for 3 months, the DON or ADON will report the findings of the monitoring ensuring resident requiring O2 had accurate orders and flow rates transcribed to the EMAR per licensed provider orders, concentrators/O2 cylinders regulators reflect the ordered flow rate, O2 care and assessment per facility protocol, and accurate O2 care plan and interventions monthly Quality Improvement (QI) Committee meeting. The QI Committee will review for further recommendations for follow up as needed or continued compliance to determine the need and/or frequency of the continued QI monitoring to ensure compliance is maintained. Date of completion 06/09/2022.	
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident, staff, Medical Director (MD) and Physician #1 interviews, the facility failed to obtain and implement Physician orders for the care and	F 698	On 5/11/22during a recertification and complaint survey at Richmond Pines Healthcare and Rehabilitation Center, the survey team observed Resident #17 did	6/9/22

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F 698	Continued From page 60 monitoring of a resident on hemodialysis (Resident #17). This was for 1 of 1 resident reviewed for dialysis. The findings included: Resident #17 was admitted on 6/26/21 and readmitted on 2/19/22 with a diagnosis of End Stage Renal Disease (ESRD) requiring dialysis. His readmission Minimum Data Set dated 2/26/22 was coded for receiving dialysis treatments. Resident #17 was care planned on 3/9/22 for ESRD with a risk for complications due to hemodialysis. Interventions included dialysis on Tuesdays, Thursdays and Saturdays, no blood draws or blood pressure (BP) in his dialysis access arm, monitoring the access site for bleeding/infection and monitoring his vital signs per facility protocol. Review of Resident #17's April and May 2022 Physician orders did not include any orders related to dialysis or his dialysis access site. Review of Resident #17's April and May 2022 medication administration records (MARs) and treatment administration records (TARs) did not include any documentation related to dialysis or his dialysis access site. Review of Resident #17's dialysis communication sheets from 4/12/22 to 5/10/22 included 3 occasions of documented evidence that his right upper arm dialysis fistula was assessed for a thrill (vibrations felt when touching the fistula) and a bruit (a loud swishing sound when listening to the fistula using a stethoscope). The dialysis communication sheets did not include any documented evidence that his fistula site was	F 698	not have Licensed Provider orders and/or facility protocols in place for care and monitoring of resident on hemodialysis. Resident #17 continues to reside at the facility and continues to require hemodialysis. On 5/10/22, Director of Nursing (DON) obtained and implemented orders on the EMAR/ETAR for care and monitoring of resident on hemodialysis to include care, monitoring, and assessment of dialysis shunt/fistula. Root Cause: Nurses did not obtain or implement Licensed Provider orders on the EMAR/ETAR for care and monitoring of resident on hemodialysis to include care, monitoring, and assessment of dialysis shunt/fistula. All dialysis residents have the potential to be affected by this alleged deficient practice. The corrective actions set forth will be utilized for any residents found to be in a similar situation as Resident #17 to include standing orders for care and monitoring and assessment of shunt/fistula site. On 5/10/22, the Director of Nursing completed 100% audit of residents requiring orders for care and monitoring of resident on hemodialysis to include care, monitoring, and assessment of dialysis shunt/fistula. On 5/10/22, the Assistant Director of Nursing (ADON), Treatment Nurse, and	

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F 698	Continued From page 61 monitored for bleeding. Review of Resident #17's nursing notes from 4/10/22 through 5/11/22 included 2 occasions of documented evidence that his dialysis fistula was assessed on 5/5/22 at 5:30 PM for a thrill and bruit and on 5/6/22 at 9:20 AM his fistula was assessed for a thrill and bruit and the appearance of his fistula dressing. There was no documented evidence that his fistula was monitored after his dialysis treatments for signs of bleeding. An observation and interview was completed with Resident #17 on 5/9/22 at 2:40 PM. He stated he just returned from having his dialysis fistula unclogged (image-guided surgical procedure to reopen a fistula). An interview and observation was completed on 5/11/22 at 11:13 AM with Resident #17. He was wearing a white undershirt under a short sleeve button down shirt. Observed were several spots of blood each approximately the size of nickel on his white undershirt over his fistula site. Resident #17 stated he removed the dressing earlier this morning and "it bled a little bit". He also presented a white wash cloth with multiple small spots of blood on it. Resident #17 stated the facility staff did not routinely check his vital signs or look at his fistula dressing for bleeding after his treatments, but sometimes they checked his fistula for a thrill and bruit. He stated the facility staff knew not to get any lab work or BP's in his right arm. An interview was completed on 5/10/22 at 10:50 AM with Nursing Assistant (NA) #6. She stated no lab work or blood pressure (BP) checks were done to Resident #17's right arm because that	F 698	Quality Assurance & Improvement Nurse obtained and implemented orders for care and monitoring of resident on hemodialysis to include care, monitoring, and assessment of dialysis shunt/fistula. The Staff Development Coordinator (SDC), Director of Nursing (DON), Assistant Director of Nursing (ADON), and Regional Clinical Nurse Consultant will begin education to facility department heads, therapy staff, and facility/agency nursing staff on 6/1/22 on obtaining and implementing orders for care and monitoring of resident on hemodialysis to include care, monitoring, and assessment of dialysis shunt/fistula. This education also included no blood pressures or needle sticks to access arm. This education will be completed on 6/8/22. On 6/1/22, the SDC added this education to the new hire packet and agency/contract staff packet. On 6/9/22, the Staff Development Coordinator will mail education to any Contracted Agency/Facility Nursing Staff that had not completed education of on obtaining and implementing orders for care and monitoring of resident on hemodialysis to include care, monitoring, and assessment of dialysis shunt/fistula. After 6/8/22, no Contracted Agency/Facility Nursing Staff will be allowed to work until education on on obtaining and implementing orders for care and monitoring of resident on hemodialysis to include care, monitoring, and assessment of dialysis shunt/fistula.	

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F 698	Continued From page 62 was where his dialysis site was. NA #6 stated the nurses normally asked the aides to get vital signs on Resident #17 when he returned from his treatments but the nurses were responsible for checking his fistula to make sure it wasn't clogged, absent of bleeding and removing his fistula dressing after each treatment. She stated if she noticed any bleeding from his fistula, she would immediately inform his nurse. An interview was completed on 5/11/22 at 11:30 AM with Nurse #1. She confirmed she was assigned to Resident #17 on 5/9/10, 5/10/22 and today. She stated she obtained Resident #17's vital signs before each dialysis treatment, but she was not aware that his vital signs should be obtained after his treatments. Nurse #1 stated she was not aware that Resident #17's dialysis fistula should be assessed daily for a thrill and bruit, his fistula dressing monitored for signs of bleeding or leaving the fistula dressing in place for 24 hours after his treatments. She stated Resident #17 would remove his own dressing after his dialysis treatments sometime the following day. An interview was completed on 5/11/22 at 4:10 PM with Nurse #9. She stated she received Resident #17's from dialysis on 5/5/22 and was aware that Resident #17's vital signs should be obtained before and after each dialysis treatment but must have forgotten to document it. She stated she routinely checked his fistula dressing for signs of bleeding and his fistula for a thrill and bruit. Nurse #9 stated Resident #17 knew not to remove his fistula dressing until the following day. An interview was completed on 5/12/22 at 10:10 AM with Nurse #2. She stated she was not aware of the need to obtain Resident #17's vital signs	F 698	Beginning 6/9/22 22 the SDC, DON, ADON, Treatment Nurse, QA&I Nurse, and/or assigned special project department head will complete monitoring to ensure compliance on obtaining and implementing orders for care and monitoring of resident on hemodialysis to include care, monitoring, and assessment of dialysis shunt/fistula. The SDC, DON, ADON, Treatment Nurse, QA&I Nurse, and/or assigned special project department head will observe 6 random residents 5x/week x 4 weeks, then 3x/week x4weeks, then 2x/week x4 weeks ensure compliance on obtaining and implementing orders for care and monitoring of resident on hemodialysis to include care, monitoring, and assessment of dialysis shunt/fistula. Beginning 6/15/22, ADON, DON, Treatment Nurse and/or QA&I nurse will report the findings of the monitoring: on obtaining and implementing orders for care and monitoring of resident on hemodialysis to include care, monitoring, and assessment of dialysis shunt/fistula to the members of the Cardinal Intradisciplinary Team once weekly x3 months to ensure compliance and review for further recommendations and/or follow up as needed for continued compliance. Beginning the month of July 2022 and continuing for 3 months, ADON, DON, and/or QA&I nurse will report the findings of the monitoring on obtaining and implementing orders for care and	

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F 698	Continued From page 63 after his dialysis treatments. She stated she did assess his fistula dressing for bleeding but frequently forgot to assess for a thrill and bruit. An interview was completed on 5/11/22 at 8:55 AM with the Assistant Director of Nursing (ADON). She stated the nurses monitored Resident #17's fistula for bleeding and obtained his vital signs after each treatment. An interview was completed with the Administrator and the Director of Nursing (DON) on 5/12/22 at 1:15 PM. The DON stated she excepted the staff to obtain Physician orders, implement those orders and be knowledgeable regarding the care of a dialysis resident to include Resident #17. The DON stated it was the responsibility of the floor nurses to ensure all Physician orders were obtained and any required monitoring be entered into the electronic medical record (EMAR) on admission and readmission. A telephone interview was completed on 5/12/22 at 10:44 AM with Physician #1. He stated he was under the impression that the facility implemented standing orders for dialysis residents and was not aware Resident #17 did not have any orders. The Physician stated it was his expectation that the facility contact him for any missing orders and implement those orders for Resident #17 An interview was completed on 5/11/22 at 9:05 AM with the MD. He stated he was not Resident #17's Physician but it was his expectation that there be written orders for dialysis. He stated there should be orders for the assessment of a thrill and bruit, vital signs, signs of bleeding and leaving his fistula dressing in place for 24 hours before removing.	F 698	monitoring of resident on hemodialysis to include care, monitoring, and assessment of dialysis shunt/fistula. monthly Quality Improvement (QI) Committee meeting. The QI Committee will review for further recommendations for follow up as needed or continued compliance to determine the need and/or frequency of the continued QI monitoring to ensure compliance is maintained. Date of completion 06/09/2022.	

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F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758		6/9/22

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F 758	Continued From page 65 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with staff and the Medical Director, the facility failed to ensure as needed psychotropic medications were time limited in duration for 2 of 5 residents reviewed for unnecessary medications (Residents #50 and #59). The findings included: 1. Resident #50 was originally admitted to the facility on 10/30/20 with a recent readmission date of 3/8/22. Her diagnoses included dementia, depression, and anxiety disorder. A quarterly Minimum Data Set (MDS) assessment dated 3/15/22 indicated Resident #50 had moderately impaired cognition and was coded with receiving 3 days of an antianxiety medication during the assessment period. A review of the active physician orders revealed an order dated 3/24/22 for Alprazolam (Xanax-an antianxiety medication) give 0.5 milligrams (mg) every eight hours as needed (PRN) for anxiety. This order for PRN Alprazolam had no stop date and was entered into the Electronic Medical Record (EMR) by the Assistant Director of Nursing (ADON) when the facility changed over	F 758	On 5/11/22 during a recertification and complaint survey at Richmond Pines Healthcare and Rehabilitation Center, the survey team observed Resident #50, and Resident #59 did not obtain time limited duration orders from Licensed Provider for as needed psychotropic medications. Resident #50 continues to reside at the facility. Resident #59 continues to reside at the facility. On 5/11/22, Resident #50 as needed psychotropic medications were clarified with the licensed provider with stop dates and were corrected on the EMAR. On 5/11/22, Resident #50 as needed psychotropic medications were clarified with the licensed provider with stop dates and were corrected on the EMAR. Root Cause: Licensed Provider did not give orders for stop dates on as needed psychotropic medications, and the nurse did not contact the license provider for clarification of stop dates on as needed psychotropic medications.	

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F 758	Continued From page 66 from paper to electronic medical records on 4/19/22. Further review of Resident #50's April 2022 and May 2022 Medication Administration Record (MAR) indicated she had orders for Alprazolam that had been discontinued as follows: - Alprazolam 0.5 mg 1 tablet by mouth every 8 hours as needed for anxiety from 4/7/22 to 4/17/22. Resident #50 received this medication on 4/7/22. - Alprazolam 0.25 mg give one-half tablet by mouth every 12 hours as needed for anxiety from 4/19/22 to 5/5/22. Resident #50 received this medication on 5/4/22. The April 2022 and May 2022 MARs revealed Resident #50 had received as needed dosages of the Alprazolam that was initiated on 3/24/22 with no stop date, two times in April and six times in May. A review of the pharmacy medication reviews indicated they were completed monthly with the last review dated 4/14/22. An interview occurred with the Medical Director on 5/11/22 at 9:45 AM, who stated he was aware of the regulation that required all PRN psychotropic medications to be time limited in duration. He indicated it was error if a stop date was not included in a physician's order for the PRN psychotropic medication. The ADON was interviewed on 5/11/22 at 11:40 AM and reviewed Resident #50's medical record to include the April 2022 and May 2022 MARs. She explained the facility had recently merged over to EMR records and felt the order had been	F 758	All residents have the potential to be affected by this alleged deficient practice. The corrective actions set forth will be utilized for any residents found to be in a similar situation as Residents #50 & 59. On 5/25/22, the Assistant Director of Nursing completed 100% audit of residents requiring stop dates on as needed psychotropic medications orders. Licensed providers were notified of any concerns at that time for clarification orders and corrections were made on the resident EMAR of stop dates on as needed psychotropic medications. On 6/1/22, the Staff Development Coordinator (SDC), Director of Nursing (DON), Assistant Director of Nursing (ADON), and Regional Clinical Nurse Consultant began education to facility department heads, and facility/agency nursing staff on obtaining and implementing stop dates on as needed psychotropic medications orders. This education will be completed on 6/8/22. On 6/1/22, the SDC added this education to the new hire packet and agency/contract staff packet. On 6/9/22, the Staff Development Coordinator will mail education to any Contracted Agency/Facility Nursing Staff that had not completed education of on obtaining and implementing stop dates on as needed psychotropic medications orders. After 6/8/22, no Contracted	

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F 758	Continued From page 67 entered in error. She confirmed Resident #50 had been on Alprazolam for a while with time limited orders in the past. She was aware of the need for a stop date to provide reassessment of the medication and felt the order dated 3/24/22 was an oversight. 2. Resident #59 was originally admitted to the facility on 4/23/21 with a recent readmission date of 4/16/22. Her diagnoses included anxiety disorder, dementia, bipolar disorder, and paranoid schizophrenia. A review of the pharmacy medication reviews indicated they were completed monthly with the last review dated 3/17/22. The pharmacist was unable to complete a medication review on 4/14/22 as Resident #59 was in the hospital. A review of the active physician orders revealed an order dated 4/18/22 for Lorazepam (Ativan-an antianxiety medication) 0.5 milligrams (mg)- give a half of a tablet by mouth every 24 hours as needed (PRN) for anxiety. This order for PRN Lorazepam had no stop date and was entered into the Electronic Medical Record (EMR) by the Assistant Director of Nursing (ADON). A quarterly Minimum Data Set (MDS) assessment dated 4/22/22 indicated Resident #59 had severely impaired cognition. The use of antianxiety medications was not coded for during the assessment period. Review of the April 2022 and May 2022 Medication Administration Records (MARs) revealed Resident #59 had received as needed dosages of the Lorazepam, once in April and	F 758	Agency/Facility Nursing Staff will be allowed to work until education on obtaining and implementing stop dates on as needed psychotropic medications orders. Beginning 6/9/22, the SDC, DON, ADON, Treatment Nurse, QA&I Nurse, and/or assigned special project department head will complete monitoring to ensure compliance on obtaining and implementing stop dates on as needed psychotropic medications orders. The SDC, DON, ADON, Treatment Nurse, QA&I Nurse, and/or assigned special project department head will observe 6 random residents 5x/week x 4 weeks, then 3x/week x4weeks, then 2x/week x4 weeks ensure compliance on obtaining and implementing stop dates on as needed psychotropic medications orders. Beginning 6/15/22, ADON, DON, Treatment Nurse and/or QA&I nurse will report the findings of the monitoring: obtaining and implementing stop dates on as needed psychotropic medications orders to the members of the Cardinal Intradisciplinary Team once weekly x3 months to ensure compliance and review for further recommendations and/or follow up as needed for continued compliance. Beginning the month of July 2022 and continuing for 3 months, ADON, DON, and/or QA&I nurse will report the findings of the monitoring on obtaining and implementing stop dates on as needed psychotropic medications orders monthly	

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F 758	Continued From page 68 none in May. An interview occurred with the Medical Director on 5/11/22 at 9:45 AM, who stated he was aware of the regulation that required all PRN psychotropic medications to be time limited in duration. He indicated it was error if a stop date was not included in a physician's order for the PRN psychotropic medication. The ADON was interviewed on 5/11/22 at 11:40 AM and reviewed Resident #59's medical record to include the April 2022 and May 2022 MARs. She confirmed Resident #59 had an order for Lorazepam with no stop date, was aware of the need for a stop date to provide reassessment of the medication and felt it was an oversight to not have obtained a stop date when the order was received.	F 758	Quality Improvement (QI) Committee meeting. The QI Committee will review for further recommendations for follow up as needed or continued compliance to determine the need and/or frequency of the continued QI monitoring to ensure compliance is maintained. Date of completion 06/09/2022.	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Medical Director interviews, the facility failed to administer an antipsychotic medication as ordered by a physician, for a resident with aggressive behaviors (Resident #59). This was for 1 of 1 residents reviewed for behavioral and emotional status. The findings included: Resident #59 was admitted to the facility on	F 760	On 5/11/22 during a recertification and complaint survey at Richmond Pines Healthcare and Rehabilitation Center, the survey team noted Resident #59 was not administered an intramuscular, antipsychotic medication for aggressive behaviors on 5/6/22 as ordered. Resident #59 continues to reside at the facility.	6/9/22

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F 760	Continued From page 69 4/23/21 with a recent readmission date of 4/16/22. Her diagnoses included dementia, anxiety disorder, bipolar disorder, and paranoid schizophrenia. A quarterly Minimum Data Set (MDS) assessment dated 4/22/22 indicated Resident #59 had severe cognitive impairment and received 7 days of an antipsychotic medication during the assessment period. A psychiatric progress note was reviewed for 5/5/22 and indicated Resident #59 had noncompliance with oral medication, with a decision to begin Risperdal Consta (an antipsychotic medication) injections for improvement in her combative behaviors. Her aggression was defined as impulsive with no identifiable triggers. The active physician orders were reviewed for Resident #59 and included an order dated 5/5/22 for Risperdal Consta ER (an antipsychotic medication) 12.5 milligrams (mg). Inject 12.5 mg intramuscularly one time a day every 14 days related to paranoid schizophrenia. A review of Resident #59's May 2022 Medication Administration Record (MAR) indicated Risperdal Consta 12.5 mg injection was added to the MAR on 5/6/22. The entry dated 5/6/22 indicated the medication was not available in the facility. The next administration of the Risperdal Consta injection was marked as 5/20/22 on the May 2022 MAR. The medication had not been administered as of review on 5/11/22. Review of Resident #59's pharmacy records	F 760	On 5/11/22, the licensed provider was notified of the omitted intramuscular antipsychotic medication for aggressive behaviors on 5/6/22 as ordered for Resident #59. Licensed provider initiated a follow up order to administer the intramuscular antipsychotic medication for aggressive behaviors on 5/11/22. This updated order was transcribed to Resident #59 EMAR and medication was given as ordered on 5/11/22. Root Cause: Assigned nurse clicked off the medication on the EMR as 'not available' on 5/6/22, and the order did not re-populate on the EMAR. All residents have the potential to be affected by this alleged deficient practice. The corrective actions set forth will be utilized for any residents found to be in a similar situation as Resident #59. On 5/11/22 & 5/12/22, the Assistant Director of Nursing, Assistant Director of Nursing, Quality Assurance & Improvement Nurse, Treatment Nurse completed 100% audit of residents' orders to ensure all medications are in the facility as per licensed provider orders. Any medications noted to not be in the facility were obtained at that time. On 6/1/22, the Staff Development Coordinator (SDC), Director of Nursing (DON), Assistant Director of Nursing (ADON), and Regional Clinical Nurse Consultant began education to facility department heads, and facility/agency	

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F 760	Continued From page 70 indicated Risperdal Consta 12.5 mg injection was dispensed by the pharmacy on 5/6/22 and received at the facility on 5/6/22. Review of Resident #59's nursing progress notes from 2/1/22 to 5/11/22 revealed she had aggressive behaviors towards staff, her family and other residents that consisted of throwing liquids and food, laying on the floor, hitting, kicking, biting, spitting, and pinching. An observation of Resident #59 occurred on 5/9/22 at 12:35 PM. While staff were assisting to the table for lunch she grabbed the Nurse Aide's (NA) arm and pinched her as well as hit her glasses to the floor. She attempted to step on the glasses, but the NA pushed them away with her foot. She was redirected to her seat and served her lunch meal. On 5/10/22 at 1:30 PM, an interview occurred with Nurse #3. She explained the psychiatric provider assessed Resident #59 on 5/6/22 and after a care plan meeting with the family a new order was provided for Risperdal Consta injections every 14 days. Nurse #3 stated she was assigned to Resident #59 on the day shift (7:00 AM to 3:00 PM) and the order was sent to the pharmacy so it would be sent with the evening medication delivery. Nurse #3 stated she had not cared for Resident #59 since then but stated the medication typically would have been provided the following day, after it was delivered from the pharmacy. The Medical Director was interviewed on 5/11/22 at 9:45 AM and stated he was aware of Resident #59's impulsive and aggressive behaviors. He added the psychiatric provider spoke with him	F 760	nursing staff on education of not clicking medications off on the EMAR as not given and included notifying the pharmacy for the estimated delivery on any needed medication and notifying the Director of Nursing and/or the Administrator for additional guidance. This education will be completed on 6/8/22. On 6/1/22, the SDC added this education to the new hire packet and agency/contract staff packet. On 6/9/22, the Staff Development Coordinator will mail education to any Contracted Agency/Facility Nursing Staff that had not completed education of not clicking medications off on the EMAR as not given and included notifying the pharmacy for the estimated delivery on any needed medication and notifying the Director of Nursing and/or the Administrator for additional guidance. After 6/8/22, no Contracted Agency/Facility Nursing Staff will be allowed to work until education on not clicking medications off on the EMAR as not given and notifying the pharmacy for the estimated delivery and notifying the Director of Nursing and/or the Administrator for additional guidance. Beginning 6/9/22, the SDC, DON, ADON, Treatment Nurse, Quality Assurance & Improvement (QA&I) Nurse, and/or assigned special project department head will complete monitoring to ensure to ensure all medications are in the facility as per licensed provider orders. The SDC, DON, ADON, Treatment Nurse, QA&I	

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F 760	Continued From page 71 regarding the initiation of the Risperdal Consta injections in hopes of decreasing some of the combative behaviors on 5/6/22, since Resident #59 often refused or spit out her oral medications. The Medical Director was unaware the Risperdal Consta injections had not been administered as of today and would have expected it to be started the following day after receival from the pharmacy but believed Resident #59 had no negative effects from not initiating the medication. An interview occurred with the Assistant Director of Nursing (DON) on 5/11/22 at 1:10 PM. After review of Resident #59's medical record and May 2022 MARs, the ADON verified the Risperdal Consta injection had not been provided to Resident #59 as of yet. She explained the facility had just started with Electronic Medical Records (EMR) and when the Risperdal Consta was marked as not available on 5/6/22 it didn't repopulate each day to alert staff it had not been provided. She stated the next dose to be administered was 5/20/22 at 8:00 AM and that is when it would pop up again. The ADON stated Resident #59 had daily behaviors of aggression towards staff, her family and other residents and would have expected the medication to be initiated as soon as it was received from the pharmacy.	F 760	Nurse, and/or assigned special project department head will observe 6 random residents 5x/week x 4 weeks, then 3x/week x4 weeks, then 2x/week x4 weeks to ensure all medications are available in the facility as per licensed provider orders. Beginning 6/15/22, ADON, DON, Treatment Nurse and/or QA&I nurse will report the findings of the monitoring to ensure all medications are available in the facility as per licensed provider orders to the members of the Cardinal Intradisciplinary Team once weekly x3 months to ensure compliance and review for further recommendations and/or follow up as needed for continued compliance. Beginning the month of July 2022 and continuing for 3 months, ADON, DON, and/or QA&I nurse will report the findings of the monitoring on ensure all medications are available in the facility as per licensed provider orders monthly Quality Improvement (QI) Committee meeting. The QI Committee will review for further recommendations for follow up as needed or continued compliance to determine the need and/or frequency of the continued QI monitoring to ensure compliance is maintained. Date of completion 06/09/2022.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F 761		6/9/22

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RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345

(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 761	Continued From page 72 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard three expired insulin vials and failed to date one insulin vial when opened for 1 of 2 medication carts reviewed for medication storage (400 hall- SPARKS). The findings included: A review of the facility policy titled "Insulin Storage" dated 6/2021 read in part, that insulin vials and pens should be dated upon opening and unused portions discarded within the timeframe recommended by the manufacturer.	F 761	On 5/12/22, during a recertification and complaint survey at Richmond Pines Healthcare and Rehabilitation Center, the survey team observed three vials of expired insulin on the 400 hall-SPARKS medication cart. Resident #50, #42 currently live in the facility and could have potentially been affected by this deficient practice. On 5/12/22, the Assistant Director of Nursing removed the three vials of	

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F 761	Continued From page 73 On 5/12/22 at 10:56 AM, an observation of the medication cart for the 400 hall SPARK unit was conducted with Nurse #8. Items discovered included: - 70/30 Insulin vial for Resident #50 was opened and undated. - 70/30 Insulin vial for Resident #50 was dated as opened on 3/25/22. A label was present that read to discard 28 days after opening. - Levemir Insulin vial for Resident #42 was dated as opened on 3/17/22. A label was present that read to discard 28 days after opening. - Novolog Insulin vial for Resident #42 was dated as opened on 3/20/22. A label was present that read to discard 28 days after opening. In an interview on 5/12/22 at 11:05 AM, Nurse #8 stated she hadn't noticed the medications were expired or not dated and wasn't assigned to that hall frequently. She was unable to state who checked the medication carts routinely for expired and undated medications and had not checked prior to giving the medications. On 5/12/22 at 1:15 PM, an interview occurred with the Director of Nursing. She stated it was expected for insulin vials to be dated when opened and discarded at the recommended time frame. She stated all nurses should be reviewing the medications to ensure they had not expired.	F 761	expired insulin and disposed of them as per facility protocol. Root Cause: Assigned nurse did remove three vials of expired insulin from the SPARKS medication cart and dispose of these expired vials of insulin per facility protocol. All residents have the potential to be affected by this alleged deficient practice. Cart audits by floor nurses per facility protocol will be verified by a Clinical Administrative Registered Nurse to protect residents in similar situations. On 5/12/22 and 5/13/22, the Assistant Director of Nursing, Assistant Director of Nursing, Quality Assurance & Improvement Nurse, Treatment Nurse completed 100% audit of facility medications and removed any expired medications from the medication carts and disposed of them per facility protocol. On 6/1/22, the Staff Development Coordinator (SDC), Director of Nursing (DON), Assistant Director of Nursing (ADON), and Regional Clinical Nurse Consultant began education to facility department heads, and facility/agency nursing staff on checking medications including multi vial medication expiration dates and exposing of them per facility protocol. This education will be completed on 6/8/22. On 6/1/22, the SDC added this education to the new hire packet and agency/contract staff packet.	

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F 761	Continued From page 74	F 761	On 6/9/22, the Staff Development Coordinator will mail education to any Contracted Agency/Facility Nursing Staff that had not completed education of checking medications including multi vial medication expiration dates and exposing of them per facility protocol After 6/8/22, no Contracted Agency/Facility Nursing Staff will be allowed to work until education on checking medications including multi vial medication expiration dates and exposing of them per facility protocol Beginning 6/9/22, the SDC, DON, ADON, Treatment Nurse, Quality Assurance & Improvement (QA&I) Nurse, and/or assigned special project department head will complete monitoring to ensure expired medications are removed from medication carts and exposing them per facility protocol The SDC, DON, ADON, Treatment Nurse, QA&I Nurse, and/or assigned special project department head will observe 6 random residents 5x/week x 4 weeks, then 3x/week x4weeks, then 2x/week x4 weeks to ensure expired medications are removed from medication carts and exposing them per facility protocol. Beginning 6/15/22 ADON, DON, Treatment Nurse and/or QA&I nurse will report the findings of the monitoring to ensure all expired medications are removed from medication carts and exposing them per facility protocol to the members of the Cardinal Intradisciplinary Team once weekly x3 months to ensure	

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F 761	Continued From page 75	F 761	compliance and review for further recommendations and/or follow up as needed for continued compliance. Beginning the month of July 2022 and continuing for 3 months, ADON, DON, and/or QA&I nurse will report the findings of the monitoring on ensure all expired medications are removed from medication carts and exposing them per facility protocol monthly Quality Improvement (QI) Committee meeting. The QI Committee will review for further recommendations for follow up as needed or continued compliance to determine the need and/or frequency of the continued QI monitoring to ensure compliance is maintained. Date of completion 06/09/2022.	
F 842 SS=E	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-	F 842		6/9/22

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F 842	Continued From page 76 (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care 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;	F 842		

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F 842	Continued From page 77 (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to maintain complete and accurate medical records in the areas pressure ulcer treatments, (Resident #30, Resident #38 and Resident #17) and surgical wound treatments (Resident #40). This was for 4 of 20 residents reviewed for accurate and complete medical records. The findings included: 1. Resident #30 was admitted on 3/3/22 with a pressure ulcer to his sacrum. His admission Minimum Data Set (MDS) dated 3/10/22 indicated he was coded for 2 stage pressure ulcers. Review of Resident #30's wound consult dated 5/2/22 indicated the area on his left buttock was described as his sacrum. The area was debrided and a new order for an alternating air mattress (AAM). Review of Resident #30's May 2022 Physician orders indicted there were new wound care orders dated 5/3/22. Review of Resident #30's May 2022 Treatment	F 842	On 5/11/22 during a recertification and complaint survey at Richmond Pines Healthcare and Rehabilitation Center, the survey team noted Resident #30, Resident #38, Resident #17, and Resident #40 had incomplete (omissions) medical records. 1. Resident #30 no longer resides at the facility. 2. Resident #38 continues to reside at the facility and was noted with omissions on pressure ulcer treatment orders. 3. Resident #17 continues to reside at the facility and was noted with omissions on pressure ulcer treatment orders. 4. Resident #40 continues to reside at the facility and was noted with omissions on surgical wound treatment orders. 2. Resident #38 has had no adverse affect from the omitted documentation 3. Resident #17 has had no adverse affect from the omitted documentation 4. Resident #40 has had no adverse affect from the omitted documentation	

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F 842	Continued From page 78 Administration Record (TAR) revealed no documented evidence his wound care was provided on 5/3/22, 5/5/22, 5/6/22, 5/8/22 and 5/11/22. Review of Resident #30's nursing notes from 5/1/22 to 5/11/22 did not include any documented evidence of wound care refusals. An interview with the Treatment Nurse (TN) was completed on 5/11/22 at 4:50 PM. He reviewed Resident #30's May TAR and acknowledged there was no documentation of his wound care on the days identified. He stated the wound care was completed as ordered for Resident #30 but he needed to improve his documentation by initialing off in Resident #30's electronic medical record (EMR). He stated he had not gotten used to documenting in the EMR. An interview was completed with the Administrator and the Director of Nursing (DON) on 5/12/22 at 1:15 PM. The DON explained the facility had recently transitioned from paper to electronic TAR's on 4/19/22 but expected the Treatment Nurse as well as any other nursing staff to sign off when wound care was completed or indicate if it was refused by the resident. 2. Resident #38 was admitted on 11/28/17and recently readmitted on 11/4/21 with pressure ulcers to his right and left heels. His quarterly Minimum Data Assessment dated 4/18/22 indicated he was coded for one stage 3 pressure ulcer and 3 venous ulcers. Review of Resident #38's April 2022 Physician	F 842	Root Cause: Treatment Nurse states he is having trouble with the documentation on Electronic Treatment System All residents have the potential to be affected by this alleged deficient practice. On 5/13/22, the Assistant Director of Nursing, implemented additional one on one training on the ETAR system. On 6/1/22 the Staff Development Coordinator (SDC), Director of Nursing (DON), Assistant Director of Nursing (ADON), and Regional Clinical Nurse Consultant began education to facility department heads, and facility/agency nursing staff on checking for omissions and correcting any omissions in the Electronic Medication & treatment Record System before leaving for your shift. This education will be completed on 6/8/22. On 6/1/22 the SDC added this education to the new hire packet and agency/contract staff packet. On 6/9/22 the Staff Development Coordinator will mail education to any Contracted Agency/Facility Nursing Staff that had not completed education of checking for omissions and correcting any omissions in the Electronic Medication & treatment Record System before leaving for your shift After 6/8/22, no Contracted Agency/Facility Nursing Staff will be allowed to work until education on checking for omissions and correcting any omissions in the Electronic Medication &	

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F 842	Continued From page 79 orders indicted there were new wound care orders dated 4/1/22. Review of Resident #38's April 2022 Treatment Administration Record (TAR) revealed no documented evidence his wound care was provided on 4/21/22, 4/24/22, 4/26/22 and 4/30/22. Review of Resident #38's May 2022 TAR revealed no documented evidence his wound care was provided from 5/6/22 through 5/10/22. Review of Resident #38's nursing notes from 4/19/22 to 5/11/22 did not include any documented evidence of wound care refusals. An interview with the Treatment Nurse (TN) was completed on 5/11/22 at 4:50 PM. He reviewed Resident #38's May TAR and acknowledged there was no documentation of his wound care on the days identified. He stated the wound care was completed as ordered for Resident #38 but he needed to improve his documentation by initialing off in Resident #38's electronic medical record (EMR). He stated he had not gotten used to documenting in the EMR. An interview was completed with the Administrator and the Director of Nursing (DON) on 5/12/22 at 1:15 PM. The DON explained the facility had recently transitioned from paper to electronic TAR's on 4/19/22 but expected the Treatment Nurse as well as any other nursing staff to sign off when wound care was completed or indicate if it was refused by the resident. 3. Resident #17 was admitted on 6/26/21 and	F 842	treatment Record System before leaving for your shift Beginning 6/9/22 22 the SDC, DON, ADON, Treatment Nurse, Quality Assurance & Improvement (QA&I) Nurse, and/or assigned special project department head will complete monitoring of electronic medical records are complete daily The SDC, DON, ADON, Treatment Nurse, QA&I Nurse, and/or assigned special project department head will observe 6 random residents 5x/week x 4 weeks, then 3x/week x4weeks, then 2x/week x4 weeks to ensure electronic medical records are complete daily Beginning 6/15/22 ADON, DON, Treatment Nurse and/or QA&I nurse will report the findings of the monitoring to ensure all electronic medical records are complete daily to the members of the Cardinal Intradisciplinary Team daily x3 months to ensure compliance and review for further recommendations and/or follow up as needed for continued compliance. Beginning the month of July 2022 and continuing for 3 months, ADON, DON, and/or QA&I nurse will report the findings of the monitoring on ensure all electronic medical records are complete monthly Quality Improvement (QI) Committee meeting. The QI Committee will review for further recommendations for follow up as needed or continued compliance to determine the need and/or frequency of the continued QI monitoring to ensure compliance is maintained.	

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F 842	Continued From page 80	F 842	Date of completion 06/09/2022.	

readmitted on 2/19/22 after an amputation of all the toes on his left foot.

His readmission Minimum Data Set dated 2/26/22 was coded for a surgical wound.

Review of Resident #17's April 2022 Physician orders indicted there were new wound care orders dated 4/1/22.

Review of Resident #17's April 2022 Treatment Administration Record (TAR) revealed no documented evidence his wound care was provided on 4/20/22, 4/21/22, 4/23/22 and 4/24/22.

Review of Resident #17's May 2022 TAR revealed no documented evidence his wound care was provided on 5/3/22, 5/5/22, 5/6/22, 5/8/22 and 5/11/22.

An interview with the Treatment Nurse (TN) was completed on 5/11/22 at 4:50 PM. He reviewed Resident #17's May TAR and acknowledged there was no documentation of his wound care on the days identified. He stated the wound care was completed as ordered for Resident #17 but he needed to improve his documentation by initialing off in Resident #17's electronic medical record (EMR). He stated he had not gotten used to documenting in the EMR.

An interview was completed with the Administrator and the Director of Nursing (DON) on 5/12/22 at 1:15 PM. The DON explained the facility had recently transitioned from paper to electronic TAR's on 4/19/22 but expected the Treatment Nurse as well as any other nursing staff to sign off when wound care was completed

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F 842	Continued From page 81	F 842		

or indicate if it was refused by the resident.
4. Resident #40 was originally admitted to the facility on 1/3/22 with a readmission date of 1/18/22. His diagnoses included necrotizing fasciitis (a severe soft tissue infection that is caused by bacteria), abscess of the perineum, and type 2 diabetes.

A quarterly Minimum Data Set (MDS) assessment dated 3/17/22 indicated Resident #40 was cognitively intact and had surgical wounds present.

A review of the active physician orders for Resident #40, revealed the following orders dated 4/1/22:
- Clean the perineal wound with normal saline using gauze, pat dry with clean gauze, apply Calcium Alginate with Silver (a highly absorbent gel-like covering to help maintain a moist environment that promotes wound healing) and secure every day.
- Clean the right buttock wound with normal saline using gauzes, pat dry with clean gauze, apply Calcium Alginate with Silver and secure every day.

The April 2022 and May 2022 Treatment Administration Record (TAR) was reviewed and demonstrated the surgical wound care to Resident #40's perineum and right buttock was not initialed as completed or refused by the resident at 9:00 AM on 4/21/22, 4/26/22, 5/3/22, 5/5/22 and 5/6/22.

Review of the nursing progress notes from 1/3/22 to 5/6/22 did not include any refusals of wound care by Resident #40.

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F 842	Continued From page 82 The Treatment Nurse was interviewed on 5/11/22 at 4:50 PM and explained he completed wound care dressing changes Monday through Friday on the day shift (7:00 AM to 3:00 PM). After reviewing the missing documentation for Resident #40, on the April 2022 and May 2022 TARs, he stated he would have been on duty on those dates. The Treatment Nurse stated he had completed the wound care to Resident #40 as ordered and "needed to get better with signing off treatments in the new Electronic Medical Record system. It's just a bunch of clickity clacks on the computer and I've just not gotten the hang of it yet". On 5/12/22 at 1:15 PM, an interview was held with the Director of Nursing (DON). She explained the facility had recently transitioned from paper to electronic TAR's on 4/19/22 but expected the Treatment Nurse as well as any other nursing staff to sign off when wound care was completed or indicate if it was refused by the resident.	F 842		