STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 08/18/2022

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DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

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E 000	Initial Comments An unannounced Recertification survey was conducted on 08/15/22 through 08/18/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # HE1B11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 08/15/22 through 08/18/22. Event ID# HE1B11 . 1 of 3 complaint allegations was substantiated. Intake #NC00189460	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 578		9/13/22

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

Electronically Signed | 09/12/2022

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F 578	Continued From page 1 (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interviews, resident interview, and record review, the facility failed to determine code status on admission for 1 of 5 residents reviewed for advance directives (Resident #35). The findings included: Resident #35 was admitted to the facility on 6/9/22. Review of the History and Physical (H&P) documented by the Nurse Practitioner (NP) and dated 6/10/22 indicated hospital records were received on 6/9/22 which had no code status indicated. The NP documented "full scope of treatment, attempt resuscitation" in the code status portion of the H&P. The admission Minimum Data Set (MDS) dated 6/16/22 revealed Resident #35 was cognitively	F 578	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirements under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. How corrected Action will be accomplished for those residents found to have been affected by this deficient practice. The facility failed to identify Resident's	

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F 578	Continued From page 2 intact. Resident #35's care plan initiated 6/19/22 with a revision date of 7/21/22 did not contain information regarding code status or advance directives. A review of the electronic health record (EHR) revealed no information in the Advance Directives section of Resident #35's information dashboard. It stated, as of 8/17/22, there was "no information found" for advance directive information. As of 8/17/22, at the time of review, there was no active order for code status in Resident #35's medical record. A review of Resident #35's hardcopy chart revealed no information in the advance directive tab. An interview was conducted with Nurse #1 on 8/17/22 at 9:07 AM. Nurse #1 stated she would look in the EHR for a resident's code status. The code status was usually displayed next to the resident's picture. Nurse #1 reviewed Resident #35's medical record and stated the resident did not have a code status. She would notify the unit supervisor to have the code status updated. An interview was conducted with Resident #35 on 8/17/22 at 9:12 AM. Resident #35 revealed the facility had not spoken with her regarding her wishes for full code or do not resuscitate (DNR) status. She wanted to be considered a full code. During an interview with the director of nursing (DON) on 8/17/22 at 12:40 PM, she stated a resident's wishes were assessed upon	F 578	#35 code status on admission 6/9/22, as of 8/16/22 there was no active order for code status for resident #35. How Corrective Action will be accomplished for those residents having the potential to be affected by this same deficient practice. All residents have the potential of being affected by this deficient practice, therefore a full audit of all resident's charts were started on 8/17/22 by the Medical Records Director to ensure compliance. What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur. During the admission process the Admission Coordinator will review code status with the resident an or Responsible Party upon completing the admission paperwork, code status forms are included in the admission packet. All new admissions will be discussed during the morning clinical meeting daily. Indicate how the facility plans to monitor it's performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. All new admission charts will be reviewed within 24 hours by the Unit Coordinator and/or Director of Nursing/ADON to ensure that current resident code status is	

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F 578	Continued From page 3 admission. The physician or NP would talk to the family regarding advance directives. Nurses looked for a resident's code status under the resident profile in the EHR. If no code status was entered for a resident, they would be treated as a full code until family was contacted and the status was verified. Resident #35 should have a care plan and physician's order in the medical record regarding code status. In an interview with the NP on 8/17/22 at 12:50 PM, he stated he had a conversation with Resident #35's family about advance directives and code status when she was admitted. She was a full code. During an interview with the Administrator on 8/17/22 at 2:40 PM, she stated nurses usually enter a resident's code status order into a resident's chart. Advance directives should be addressed upon admission and entered in the resident's chart. Resident #35 should have a code status order and care plan in her medical record. A follow up interview was conducted with the NP on 8/18/22 at 11:25 AM. He stated nurses or providers could enter a resident's code status into the chart. He was contacted on 8/17/22 by the nurse for a code status order for Resident #35. He informed the nurse he had documented the code status in the resident's notes and confirmed the full code status order with the nurse.	F 578	part of the resident medical record. An audit will be completed on all new admissions to ensure compliance with code status. Audits will be conducted weekly X4 weeks, bi-weekly X 4 weeks and monthly X3 months. All negative finding will be discussed during monthly QAPI meetings	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and	F 583		9/13/22

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F 583	Continued From page 4 confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to provide privacy during personal care for 2 of 19 residents reviewed for privacy (Resident #16 and Resident #36).	F 583	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the	

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F 583	Continued From page 5 The findings included: 1. Resident #16 was admitted to the facility on 12/6/17. The quarterly Minimum Data Set (MDS) dated 5/26/22 revealed Resident #16 was severely cognitively impaired, and he required staff assistance with activities of daily living (ADLs). On 8/15/22 at 11:38 AM, Nurse Aide (NA) #4 was observed changing Resident #16's brief while he was in his bed. Resident #16 was in the bed next to the window (B-bed) and his roommate's bed was next to the door (A-bed). The privacy curtain was open and Resident #16's roommate was in the room next to the A-bed, sitting in a wheelchair, and facing into the room. The roommate was observed looking around the room while Resident #16 received incontinence care. Resident #16's roommate was not interviewable. An interview was conducted with NA #4 on 8/18/22 at 1:00 PM. She stated she usually closed the resident's curtain when performing care to provide for the resident's privacy. NA #4 indicated the therapist had been in the room and left the curtain open. 2. Resident #36 was admitted to the facility on 9/16/22. The quarterly MDS dated 6/5/22 revealed he was moderately cognitively impaired and received treatment for a pressure ulcer. On 8/16/22 at 11:25 AM, Nurse #2 was observed providing wound care to Resident #36. The resident was wearing an open brief and was uncovered from the waist down. Nurse #2 was in the room, opened the door, and left it open while	F 583	correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirements under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. How corrected Action will be accomplished for those residents found to have been affected by this deficient practice. The IDT team met on 9/6/22 to identify the root cause of this allege non compliance. Root cause analysis conducted revealed that the allege non compliance resulted from inadequate training/understanding of the staff regarding resident's rights. dignity, and the resident right to privacy while providing personal care. Resident #16 and #36, education and training was provided to all nursing staff on resident rights, dignity and the right to privacy while providing care. How Corrective Action will be accomplished for those residents having the potential to be affected by this same deficient practice. All residents have the potential to be affected by this allege non-compliance and as a result, the systemic changes stated below have been put in place to prevent any risk of affecting additional residents.	

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F 583	Continued From page 6 she gathered wound care supplies from her cart in the hallway. Resident #36's privacy curtain was open. While standing at her cart in the hallway, Nurse #2 told Resident #36 that she would be right back. She left the door open and went down the hall towards the nurse's station. During this time, staff were observed in the hallway. Nurse #2 returned to the resident's room, closed the door behind her, and positioned the resident on his side for sacral wound care. The privacy curtain was closed after the resident was positioned for wound care. Resident #36's roommate was not in the room at the time. An interview was conducted with Resident #36 on 8/16/22 at 11:40 AM. He stated it made him uncomfortable to know the door was opened and the curtain was open while he was exposed. During an interview with Nurse #2 on 8/16/22 at 11:42 AM, she stated she usually closed the curtain and doors when providing care to residents. She stated Resident #36 had recently gotten a roommate and she was not used to closing the curtain in his room. During an interview with the director of nursing (DON), on 8/17/22 at 2:30 PM, she stated the curtains and doors should be closed during care to provide for privacy. An interview was conducted with the Administrator on 8/17/22 at 2:40 PM. She stated curtains and doors should be closed when providing care to residents. Staff should provide for residents' privacy.	F 583	Education/in-service are provided for all nursing staff on resident rights, dignity and resident right's to privacy while providing personal care. Privacy curtains must be pulled to ensure privacy for all residents. This education/in-service will be completed by 9/9/22. What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur. On 9/6/22 the Administrator, and the Assistant Director of Nursing initiated re-education to all nursing staff regarding resident's right, dignity and their right to privacy while staff is providing personal care. Privacy curtains must be pulled to ensure resident privacy during personal care. Indicate how the facility plans to monitor it's performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. An audit sheet will be done by the Administrator, Director of Nursing or designee to monitor random 10 residents to ensure that all residents are treated with dignity, respect and providing privacy while rendering personal care. This monitoring process will take place daily(M-F) for 4 weeks, then weekly for 4 weeks then monthly for 2 months. The Administrator, Director of Nursing or Designee will report findings of the	

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F 583	Continued From page 7	F 583	monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		9/13/22

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F 584	Continued From page 8 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record reviews, the facility failed to clean the wall vents slats for 19 of 60 rooms observed (Rooms #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40 and #41). The findings included: Observation on 8/15/22 at 9:30 AM, the initial tour revealed the occupied room vents for 19 of 60 rooms observed (Rooms #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40 and #41) the vents had thick dust accumulation and debris on the vent slats. There were particles of dust blowing throughout the room. 1. a. Observation was conducted on 8/15/22 at 9:30 AM, Room #23, the wall vent slats inside and outside had large volumes of thick dust and debris buildup. b. Observation was conducted on 8/15/22 at 9:32AM, Room #24, the wall vent slats inside and outside had large volumes of thick dust and debris buildup.	F 584	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirements under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. How corrected Action will be accomplished for those residents found to have been affected by this deficient practice. The facility failed to clean the wall vents slat for 19 of 60 rooms. The slats in all resident's rooms have been cleaned by housekeeping on 8/18/22 and the Maintenance Director and Assistant cleaned the inside of the vents on 8/18-8/19/22 and 8/26/22 and 9/2/22.	

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F 584	Continued From page 9	F 584		

c. Observation was conducted on 8/15/22 at 9:33 AM, Room #25 the wall vent slats inside and outside had large volumes of thick dust and debris buildup.

d. Observation was conducted on 8/15/22 at 9:34 AM, Room #26 the wall vent slats inside and outside had large volumes of thick dust and debris buildup.

e. Observation was conducted on 8/15/22 at 9:35 AM, Room #27 the wall vent slats inside and outside had large volumes of thick dust and debris buildup.

f. Observation was conducted on 8/15/22 at 9:36 AM, Room #28 the wall vent slats inside and outside had large volumes of thick dust and debris buildup.

g. Observation was conducted on 8/15/22 at 9:37 AM, Room #29 the wall vent slats inside and outside had large volumes of thick dust and debris buildup.

h. Observation was conducted on 8/15/22 at 9:38 AM, Room #30 the wall vent slats inside and outside had large volumes of thick dust and debris buildup.

i. Observation was conducted on 8/15/22 at 9:39 AM, Room #31 the wall vent slats inside and outside had large volumes of thick dust and debris buildup.

j. Observation was conducted on 8/15/22 at 9:40 AM, Room #32 the wall vent slats inside and outside had large volumes of thick dust and

How Corrective Action will be accomplished for those residents having the potential to be affected by this same deficient practice.

All residents have the potential to be affected by this deficient practice, therefore the vents in the rooms were cleaned on 8/18-8/19/22.

What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur.

The cleaning of all vents will be added to the Preventive Maintenance Program for weekly cleaning. and as needed.

Indicate how the facility plans to monitor it's performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained.

The Maintenance Director will be responsible for completing weekly audits to ensure that the vents are clean. The vents will be cleaned weekly X 4 weeks, then bi-weekly X 4 weeks then monthly X 3 months. The Administrator will review weekly audits to ensure compliance. The audit tool will be brought to the monthly QAPI meetings.

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F 584	Continued From page 10	F 584		

debris buildup.

k. Observation was conducted on 8/15/22 at 9:41 AM, Room #33 the wall vent slats inside and outside had large volumes of thick dust and debris buildup.

l. Observation was conducted on 8/15/22 at 9:42 AM Room #34 the wall vent slats inside and outside had large volumes of thick dust and debris buildup.

m. Observation was conducted on 8/15/22 at 9:43 AM, Room #35 the wall vent slats inside and outside had large volumes of thick dust and debris buildup.

n. Observation was conducted on 8/15/22 at 9:44 AM, Room #36 the wall vent slats inside and outside had large volumes of thick dust and debris buildup.

o. Observation was conducted on 8/15/22 at 9:45 AM, Room #37 the wall vent slats inside and outside had large volumes of thick dust and debris buildup.

p. Observation was conducted on 8/15/22 at 9:50 AM, Room #38 the wall vent slats inside and outside had large volumes of thick dust and debris buildup.

q. Observation was conducted on 8/15/22 at 10:00 AM, Room #39 the wall vent slats inside and outside had large volumes of thick dust and debris buildup.

r. Observation was conducted on 8/15/22 at 10:05 AM, Room #40 the wall vent slats inside

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DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

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and outside had large volumes of thick dust and debris buildup.

s. Observation was conducted on 8/15/22 at 10:06 AM, Room #41, the wall vent slats inside and outside had large volumes of thick dust and debris buildup.

An interview was conducted on 8/16/22 at 10:57 AM, HK#1 stated they were responsible for cleaning resident bathrooms, empty trash, sweep/ mop floors, dust resident furniture, but not responsible for cleaning resident fans or vents. Maintenance was responsible for cleaning vents and resident fans. HK#1 stated there were 4 housekeepers during the week and 2 on weekend. There had been some HK shortage due to staff leaving and COVID and whether staff show up. There were only 2 staff on the weekend and sometimes there was no time to do vents in addition to regular assignment.

A follow-up observation was conducted on 8/16/22 at 8:30 AM and 11:00 AM, the wall vents for the identified rooms had not been cleaned and the dusty/dirty particles continued to blow throughout the rooms.

Observation of the air flow and ventilation system was done on 8/16/22 at 11:09 AM, with the Director of Nursing, Maintenance Director and District Housekeeping Manager, all confirmed the wall vent slats inside and out had large volumes of thick dust and particles blowing throughout the room and the vents had not been cleaned for a long time. The Maintenance Director did not provide a schedule or information of when the vents were last cleaned.

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An interview was conducted on 8/16/22 at 11:10 AM, Maintenance Director stated housekeeping was responsible for cleaning outside slats and maintenance was responsible for cleaning inside of the slats.

An interview was conducted on 8/16/22 at 11:15 AM, District Housekeeping Manager stated verified housekeeping was responsible for cleaning the outside slats during daily schedule as part of the high dusting process.

An interview was conducted on 8/17/22 at 9:23 AM, the Administrator stated the Maintenance Director was responsible for ensuring all residents vents were clean and operating correctly. Administrator stated the housekeeping staff was responsible for ensuring resident rooms were cleaned daily, trash emptied, floors swept/mopped, and nursing should clean up any spills from feeding tubes, liquid meds etc. The Administrator further stated housekeeping should ensure all resident rooms grills were clean and maintenance cleans the inside of vents monthly.

An interview was conducted on 8/18/22 at 9:34 AM, HK#2 stated there was a cleaning checklist that each hall for the housekeepers to follow. Typically, there would be 3 HK staff during the week and 2 staff on weekends. He stated he was aware he should be cleaning the gill on the outside of the vents and maintenance to do inside. He added due to time and assignments, the vents do not get done on a regular basis. HK#2 was observed cleaning the vents today per discussion with HK District Manager.
An interview was conducted on 8/18/22 at 10:26 AM, HK#3 stated there was a cleaning schedule for each hall during the week and a weekend

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schedule. HK#3 stated during the week the schedule may say 3 HK but only two may show, therefore some of the required tasks may not get done. HK#3 stated each hall has a checklist and the outside of the vent grills should be done as high-level cleaning, but other responsibilities were a priority, so the vents may get missed. HK#3 reported there was only 2 HK staff on the weekend and some weekends the assignment was much larger based on what was left over the week.

A follow-up interview was conducted on 8/18/22 at 10:35 AM, the District Housekeeping Manager (DHKM) stated housekeeper was responsible for cleaning all the resident rooms daily. Each hall had specific assigned areas and rooms to complete during the shift. Cleaning the outside of the high vents is part of the cleaning process and should be done during daily assignments. DHKM was shown several of the room vents and confirmed there was a large build-up of dust particles blowing from the vent. He stated the inside of the vent also needed to be cleaned and maintenance was responsible for the part. In addition, there was a modified schedule on the weekends that does not include cleaning offices. There would be 3 HK on weekdays, 1 Floor Tech, 2 laundry staff on weekend 2HK and 2 laundries. He stated since the offices were not being cleaned on the weekend, staff would be responsible for daily cleaning and vents could be caught up during this time as well as during deep cleaning which was done monthly. He stated staffing had been an issue and keeping up with all tasks had been a challenge. He stated he had been checking 3 to 4 resident rooms a day after staff completed the rooms but had not been consistent with checking vents or overall

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F 584	Continued From page 14 cleanliness of room.	F 584		
F 686 SS=D	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 record review, observation, resident, staff and the wound physician interviews, the facility failed to provide wound care of pressure ulcers per physician ' s orders for 1 of 3 residents (Resident #53) reviewed for pressure ulcers. The findings included: Resident #53 was admitted on 4/7/21. Her quarterly Minimum Data Set (MDS) assessment, dated 7/2/22, indicated Resident #53 was cognitively intact. Resident ' s diagnoses included pressure ulcer and diabetes mellitus. Resident #53 was at risk of developing pressure injuries, had one unhealed stage IV pressure ulcer, present upon admission to the facility. She received wound care, pressure reducing devices to bed and chair and nutritional management.	F 686	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirements under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. The IDT team met on 9/6/22 to identify the root cause of this alleged non-compliance. Root cause analysis conducted and revealed that the alleged non-compliance	9/13/22

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F 686	Continued From page 15 Resident #53 was always incontinent of bowel and had an indwelling urinary catheter. Review of Resident 53's plan of care, dated 7/20/22, indicated she had a pressure ulcer to her sacrum. Interventions included treatments as ordered, routine skin/wound assessment, and pressure reducing device to bed and chair. Review of the physician ' s order, dated 8/12/22, for Resident #53 revealed the following treatment to the stage IV pressure ulcer of the sacrum: cleanse with normal saline, pat dry, pack wound with collagen powder (wound treatment medication) followed by calcium alginate rope with silver (wound treatment medication), secure with foam boarder dressing every day. Review of Resident #53's Treatment Administration Record (TAR) for August 2022 revealed that the TAR reflected physician orders for the treatment to the sacral pressure ulcer and was initialed daily as completed, except for 8/5/22, 8/6/22, 8/7/22, 8/12/22, 8/13/22 and 8/14/22. On 8/16/22 at 10:15 AM, during the observation of the wound treatment for Resident #53, provided by the Nurse #2, the wound was round and approximately 1.5x1.5 cm (centimeter), pink color, with granulation and no drainage. The surrounding skin was intact. On 8/16/22 at 8:15 AM, during an observation/interview, Resident # 53 was alert and oriented. Resident indicated that she had a skin wound on her buttocks and did not receive wound treatments every day (she did not remember the exact days).	F 686	resulted from wound care How corrected Action will be accomplished for those residents found to have been affected by this deficient practice. Resident #53, the nurses were in-serviced on proper procedure, when the treatment nurse is not on duty the staff nurse must complete the task of wound care for all residents and sign the electronic record when completed How Corrective Action will be accomplished for those residents having the potential to be affected by this same deficient practice. All residents have the potential to be affected by this allege non compliance and as a result, the systemic changes stated below have been put in place to prevent any risk of affecting additional residents. Education/in-service are provided to all staff nurses. The facility procedure for completing resident wound care will be administered by the staff nurse when the treatment nurse is not on duty and sign for the treatment when completed on the electronic record. What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur. On 9/6/22 the Administrator and Assistant	

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F 686	Continued From page 16 On 8/16/22 at 8:30 AM, during an interview, Nurse #2 indicated that she was responsible for wound treatments in the facility, including Resident #53. Nurse #2 confirmed she worked on 8/5/22, 8/12/22, sometimes on weekends, and provided wound treatment for residents per physician ' s order. Nurse #2 did not remember if she provided the wound treatment for the Resident #53 on 8/5/22 and 8/12/22. On 8/17/22 at 2:05 PM, during an interview, Nurse #4 indicated she worked on 8/6/22 (Saturday), 8/7/22 (Sunday), 8/13/22 (Saturday), 8/14/22 (Sunday), and thought the wound treatment nurse was in the facility both weekends and provided wound treatments. Nurse #4 confirmed she did not complete Resident # 53 ' s wound treatments on 8/6/22, 8/7/22, 8/13/22 or 8/14/22. On 8/18/22 at 12:30 PM, during an interview, Wound Treatment Physician indicated that Resident #53 had long history of stage IV pressure ulcer on her sacral area, complicated with wound infection and osteomyelitis in the past, which had improved. Wound Treatment Physician stated he made weekly rounds in the facility and confirmed Resident 53 ' s sacral pressure ulcer was in stable condition. He expected the staff to follow the treatment orders for daily dressing changes. On 8/18/22 at 2:30 PM, during an interview, Director of Nursing (DON) indicated that the wound treatment nurse was responsible for wound treatment in the facility. When she was not available, the floor nurses should follow the physician ' s orders, conduct the wound care, and	F 686	Director of Nurses initiated re-education to the nursing staff regarding the facility procedure for the staff nurse to complete their resident wound care when the treatment wound care when the treatment nurse is not on duty and sign for the treatment when completed on the electronic record. Indicate how the facility plans to monitor it's performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. An audit sheet will be done by the Administrator, Director of Nursing or designee to monitor and ensure that all residents treatments are being completed timely and signed for on the electronic record. The Director of Nursing, The Assistant Director of Nursing or designee will check all pressure wound orders plus 5 additional treatments for completion. This monitoring process will take place daily a(M-F) for 4 weeks, weekly for 4 weeks, then monthly for 2 months. The Administrator, Director of Nursing or designee will report findings of the monitoring process 5to the facility Quality Assurance Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	

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F 686	Continued From page 17 document it in the TAR.	F 686		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to schedule a registered nurse (RN) for at least 8 consecutive hours (hrs.) a day for 3 of 48 days reviewed (7/5/22, 7/24/22, and 8/2/22). Findings included: Review of staffing sheets from 7/1/22 through 8/17/22 revealed the following: On 7/5/22 the staffing sheets indicated the facility census was 93 and "0" (zero) RN on duty. On 7/24/22 the staffing sheets indicated the facility census was 88 and "0" (zero) RN on duty. On 8/2/22 the staffing sheets indicated the facility census was 94 and "0" (zero) RN on duty. During an interview on 8/17/22 at 10:32 AM, the Scheduler stated that the facility had 3 RN and 1	F 727	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirements under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. The IDT team met on 9/6/22 to identify the root cause of this alleged non-compliance. Root cause analysis conducted and revealed that the alleged non-compliance	9/13/22

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F 727	Continued From page 18 PRN (as needed)RN and all effort were made to ensure that there was at least one RN working 8 hours shift per day. The Scheduler further stated the facility had contract with 4 staffing agencies and these agencies were contacted when there were no RN available working at least 8 consecutive hours a day. She indicated on few occasions the agencies were unable to accommodate a RN for 8 hours. She acknowledged that on 7/5/22, 7/24/22 and 8/2/22 there were no RN on duty. During an interview on 8/18/22 at 9:00 AM, the Administrator stated the facility had contracts with 4 staffing agencies. On days when there were no RN on schedule, the agencies were contacted to provide RN staff. The Administrator stated the agencies were also unable to provide RN staff all the time. Registered nurses were sent to the facility when available. The Facility was making every effort to ensure that there was a Registered nurse for 8 hrs. a day.	F 727	resulted from not having RN coverage for 8 hours on three days of the facility schedule. How corrected Action will be accomplished for those residents found to have been affected by this deficient practice. No resident named. All residents of the facility have the potential to be affected for not having RN coverage as indicated. How Corrective Action will be accomplished for those residents having the potential to be affected by this same deficient practice. All residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put in place to prevent any risk of affecting additional residents. On 8/26/22 an LPN the new staffing coordinator, is assuming the scheduler role. On 8/26/22 another agency was brought onboard to help provide RN coverage at the facility. What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur. On 9/6/22, the corporate nurse consultant provided education to the LPN, staffing coordinator on the proper scheduling process for RN coverage. An RN needs to be on the schedule for at least 8 consecutive hours, 7 days a week.	

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F 727	Continued From page 19	F 727	Indicate how the facility plans to monitor it's performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. An audit sheet will be done by the Administrator, Director of Nursing or designee to monitor and ensure that there is RN coverage of 8 hours a day listed on the schedule. This monitoring process will take place daily (M-F) for 4 weeks, then weekly for 4 weeks then monthly for 2 months.	