STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345404	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE RIVERS HEALTH AND REHAB	1403 CONNER DRIVE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The survey team entered the facility on 01/08/2021 to conduct an unannounced complaint investigation. The survey team was onsite on 01/08/2021 and 01/09/2021. Additional information was obtained offsite on 01/11/2021. Therefore, the exit date was 01/11/2021. One of the seven complaint allegations was substantiated resulting in deficiencies. Event ID# YME811.	F 000		
F 641 SS=D	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 review and staff interview the facility failed to accurately code the Minimum Data Set (MDS) to reflect skin conditions for 1 of 3 residents reviewed for pressure ulcers. (Resident #1) Findings included: Resident #1 was admitted to the facility on 07/14/2020 with diagnoses including pressure ulcer of left heel stage four, diabetes mellitus (DM) and peripheral vascular disease (PVD). A review of the most recent quarterly comprehensive MDS for Resident #1 dated 10/21/2020 indicated he was moderately impaired for daily decision making, required the extensive assistance of one person for activities of daily living including bathing, dressing and bed mobility, had no pressure ulcer, was assessed for	F 641	F641 Accuracy of Assessments For resident #1, a corrective action was obtained on 1/18/21. • The specific deficiency was corrected on 1/18/21 by modifying the Minimum Data Set assessment with an Assessment Reference Date of 10/21/20 in order to correct miscoding of the presence of a pressure ulcer in Section M0300. This correction was completed by the Regional Minimum Data Set Consultant. The corrected assessment was re-submitted and accepted by the state database on 1/19/21 in Batch #1637. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice.	2/8/21

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

Electronically Signed | 01/25/2021

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F 641	Continued From page 1 risk of pressure ulcers using a formal assessment tool, was at risk of developing pressure ulcers, had no unhealed pressure ulcers, had no other ulcers, wounds or skin problems, had a pressure relieving device for his bed and was receiving the application of dressings to his feet. A review of a care plan focus area for Resident #1 initiated 07/15/2020 indicated he had a pressure ulcer to his left heel and treatments were ordered. An additional focus area initiated 09/17/2020 and revised on 10/02/2020 indicated Resident #1 had actual skin impairment to his left heel with the potential for further skin impairment. A review of a follow-up note dated 10/14/2020 by Resident #1's facility physician indicated he had a chronic left foot wound. A review of a risk assessment dated 10/15/2020 completed by MDS Nurse #1 indicated Resident #1 had one or more unhealed pressure ulcers or injuries. A review of a medication administration note for Resident #1 dated 10/16/2020 at 6:14 PM indicated wound care was done to his left heel by the wound nurse. On 01/08/2021 at 1:59 PM an interview with Nurse #5 indicated she was currently the facility wound nurse and had been the wound nurse in October 2020. She stated she had done wound care to Resident #1's left heel wound in the past. She stated Resident #1 was admitted to the facility with the left heel pressure wound and although it was improving it had never resolved and was still being treated both in the facility with dressing changes and at the wound clinic.	F 641	A 100% audit of all current residents will be conducted in order to identify any other resident who may have been affected by this alleged deficient practice. All current residents' most recent Omnibus Budget Reconciliation Act Minimum Data Set assessment will be reviewed in order to determine if M0300 (pressure ulcers) was accurately coded. This audit was initiated 01/14/2021 and completed by the Regional Minimum Data Set Consultant 1/25/21. All coding errors that were identified during the audit were immediately modified and corrected and re-submitted to the state database. The audit results were: __32__ of __38___ residents audited were identified as having Section M0300 accurately coded. __6__ of _38____ residents audited were identified as having inaccurate coding of M0300. Systemic Changes On 1/25/21, the Regional Minimum Data Set Education and Regulatory Consultant completed an in-service training for the facility Minimum Data Set Coordinator that included the importance of thoroughly reviewing the medical record and assessing resident for the presence of pressure ulcer(s) prior to completion of M0300 of the Minimum Data Set Assessment. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators.	

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F 641	Continued From page 2 On 01/11/2021 at 12:00 PM a telephone interview with the Administrator indicated it did not sound correct that Resident #1's MDS dated 10/21/2020 indicated he did not have any wounds. She stated he still currently had the left heel wound he was admitted to the facility with and she would expect his MDS to be correct. On 01/11/2021 at 12:36 PM a telephone interview with MDS Nurse #1 indicated she was no longer employed with the facility. She stated she completed the skin portion of the MDS assessment dated 10/21/2020 and the risk assessment dated 10/15/2020 for Resident #1. She further indicated she did not have access to the facility's records and although both could not be correct she could not say which was incorrect. She went on to say she looked back at notes to complete the MDS and if notes didn't mention anything about a wound, she didn't enter any. MDS Nurse #1 indicated she did not do a full body assessment or talk to the facility wound nurse before completing the skin portion of the 10/21/2020 MDS for Resident #1.	F 641	The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing or designee will begin auditing the coding of MDS item M0300 using the quality assurance audit tool entitled “Accurate Minimum Data Set Coding Audit Tool.” This audit will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 02/08/2020	
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	F 686		2/8/21

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F 686	Continued From page 3 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 and resident, staff and physician interviews the facility failed to complete a dressing change as ordered for 1 of 3 residents reviewed for pressure ulcers. (Resident #1) Findings included: Resident #1 was admitted to the facility on 07/14/2020 with diagnoses including pressure ulcer of left heel stage four, diabetes mellitus (DM) and peripheral vascular disease (PVD). A review of the most recent comprehensive minimum data set assessment for Resident #1 dated 10/21/2020 indicated he was moderately impaired for daily decision making, required the extensive assistance of one person for activities of daily living including bathing, dressing and bed mobility, had no pressure ulcer, was assessed for risk of pressure ulcers using a formal assessment tool, was at risk of developing pressure ulcers, had no unhealed pressure ulcers, had no other ulcers, wounds or skin problems, had a pressure relieving device for his bed and was receiving the application of dressings to his feet. A review of a care plan focus area for Resident #1 initiated 07/15/2020 indicated he had a pressure ulcer to his left heel and was at risk of	F 686	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 686 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to complete a dressing change as ordered for 1 of 3 residents reviewed for pressure ulcers. (Resident #1). Root Cause analysis of area identified during the survey includes: Obtaining documentation from Residents	

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F 686	Continued From page 4 developing additional pressure ulcers due to immobility and incontinence. The care plan goal was the resident's risk for pressure ulcers would be minimized. Interventions included administer treatments as ordered, monitor for effectiveness and notify nurse of any new areas of skin breakdown. An additional focus area initiated 09/17/2020 and revised on 10/02/2020 indicated Resident #1 had actual skin impairment to his left heel with the potential for further skin impairment related to DM and PVD with a goal of will have no complications from impaired skin integrity through next review. Interventions included monitor and document location, size and treatment of skin injury. On 01/07/2021 at 9:05 AM an interview with Resident #1 indicated he entered the facility with a wound to his left heel. He stated he went to the wound clinic weekly to have his wound treated. He indicated at one point in December 2020, although he could not recall the exact date, he had gone to the wound clinic, the physician changed his heel dressing and told him his heel dressing needed to be changed every other day. According to the resident, after these new instructions were given, the facility staff did not follow them and change his wound dressing as they should have. He stated by the time the nurse changed his heel dressing the wound had seeped fluid and his foam boot was wet. He further indicated since the time the nurse found his foam boot to be wet from wound weeping, he felt his heel dressing had been changed the way it was supposed to be. According to the resident, at his last wound clinic appointment the physician told him his wound was improving. On 01/07/2021 at 10:00 AM a telephone interview	F 686	consultation appointment and Licensed Nurses initiating new orders or order changes from consultation appointment in a timely manner. An audit was conducted on the past 30 days of consultant appointments prior to the survey and no concerns identified. The Health Information Manager(HIM) and Licensed Nurses were in-serviced by the Administrator or Director of Nursing on the Consultation Process. The Process includes ensuring a consult sheet or the information from the consult, such as new orders is received upon the Resident coming back from the appointment. If any new orders or order changes, licensed nurse will enter the orders into the Medication Administration Record. An audit of the consultation process will be be conducted weekly by the Health Information Manager or designee for four weeks and monthly times 2 months. This monitoring will continue until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager. On 12-19-20, Residents dressing change	

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F 686	Continued From page 5 with Resident #1's responsible party (RP) indicated in December 2020 Resident #1 called her very upset that his heel wound dressing had not been changed like it was supposed to be. She stated Resident #1 told her he was instructed by the wound clinic physician his heel wound dressing was supposed to be changed every other day, it had not been changed for several days, and it had seeped so much fluid that his protective boot was wet. A review of a wound clinic visit report dated 12/10/2020 obtained from the wound care clinic indicated Resident #1 was seen that day for the treatment of his left heel ulcer. It further indicated after that appointment his heel dressing was to be changed on Tuesday, Thursday and Saturday. On 01/07/2021 at 10:50 AM a telephone interview with wound clinic Nurse #1 indicated when Resident #1 was sent back to the facility from the wound clinic on 12/10/2020, physician orders for Resident #1's heel wound dressing to be changed on Tuesday, Thursday and Saturday were sent back with him. She went on to say his next dressing change would have been due 12/12/2020. On 1/07/2021 at 11:35 AM an interview with Med Tech #1 indicated she was administering medication to Resident #1 on 12/12/2020 but did not perform any dressing changes as nurses did that. She stated if there was a dressing change due on a treatment administration record (TAR), she would let the nurse know. On 01/11/2020 at 9:43 AM a telephone interview with Nurse #4 indicated she was the nurse on duty supervising Med Tech #1 on 12/12/2020.	F 686	was done by a licensed nurse per doctor□s orders. The Licensed Nurses that were involved with Resident #1's plan of care were educated on Wound Documentation by the Director of Nursing on 01-19-21 and 1-20-21. The education included that all treatments are completed and signed off by the nurse prior to leaving the shift and that all treatments must have a physician order. A 100 % audit of all Residents was conducted to ensure Residents dressing changes are being done according to the physician orders. This audit was conducted by the Nurse Manager on 1-22-2021. There were no negative findings. All licensed nurses were in-serviced by the Director of Nursing. 02-08-2021 The in-service was on Wound Documentation. The education included that all treatments are completed and signed off by the nurse prior to leaving the shift and that all treatments must have a physician order. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: Any in-house staff member who did not receive in-service training by 02-08-2021, will not be allowed to work until training	

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F 686	Continued From page 6 She stated she did not recall Med Tech #1 telling her a dressing change was due or doing a heel wound dressing change for Resident #1 that day. A review of the December 2020 TAR for Resident #1 indicated Resident #1's left heel dressing was to be changed Tuesday, Thursday and Saturday at 9:00 AM beginning 12/17/2020. No dressing change was indicated on the TAR as being due on 12/12/2020. On 01/08/2021 at 11:15 AM an interview with the Administrator indicated the facility should have received paperwork back from Resident #1's wound clinic appointment on 12/10/2020. She stated she would check with the facility's medical records department to locate this paperwork. A review of a nursing progress note for Resident #1 dated 12/14/2020 at 11:15 PM written by Nurse #2 indicated Resident #1 was noted to have drainage from his left heel wound, his protective boot was wet with drainage, his heel dressing was changed, and his protective boot was laundered. On 01/08/2021 at 12:59 PM a telephone interview with Nurse #2 indicated on 12/14/2020 she received a call from Resident #1's RP who was very upset because Resident #1's heel wound dressing had not been changed. Nurse #2 stated she observed Resident #1's heel dressing was soiled, and his protective boot wet with drainage, so she provided the dressing change and laundered his protective boot. Nurse #2 went on to say although there had been no order for the dressing change on Resident #1's MAR she knew he was being seen at the wound clinic. She further indicated she found Resident #1's	F 686	has been completed. Wound Documentation Education has been integrated into the standard orientation training and in the required in-service refresher courses for licensed nurses and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Director of Nursing or Nurse Manager will audit to ensure Resident□s dressing changes are being completed per physician orders. These audits will be conducted weekly for four weeks then monthly for three months for completion of the Resident treatment administration record. This monitoring will continue until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for	

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F 686	Continued From page 7	F 686		

discharge paperwork with dressing change orders from his latest wound clinic appointment in a manilla envelope and dressing change supplies in his drawer.

On 01/11/2020 at 8:17 AM in a follow-up telephone interview Nurse #2 went on to say she documented the dressing change in Resident #1's progress notes but didn't enter his orders into the computer because she was busy.

A review of Resident #1's physician orders indicated an order entered by Nurse #3 on 12/15/2020 to change Resident #1's left heel dressing on Tuesday, Thursday and Saturday. The start date for this order was entered as 12/17/2020.

On 01/07/2021 at 12:17 PM an interview with Nurse #3 indicated she was caring for Resident #1 on 12/10/2020 when he returned from the wound clinic. She stated she received written orders from the wound clinic that day for Resident #1's dressing to be changed on Tuesday, Thursday and Saturday, indicating that Resident #1's next heel wound dressing change would have been due on Saturday 12/12/2020. She stated she looked at the orders and then put them in a basket at the nurses station meaning to enter them into the computer that day but got busy and forgot. Nurse #3 stated she left work without ever entering those orders into Resident #1's medical record. She further indicated on 12/14/2020 she received a phone call at home from the Director of Nursing (DON) telling her that Resident #1 was very upset because his left heel wound dressing had not been changed and asking her if she knew anything about that. Nurse #3 stated she then remembered she had

implementation and completion of the acceptable plan of correction.

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forgotten to enter the new wound clinic orders from 12/10/2020 into the computer, was returning to work the following day on 12/15/2020 when Resident #1's left heel wound dressing would next be due, and told the DON she would enter the orders when she returned. She went on to say on 12/15/2020 she returned to work, found the orders from the wound care clinic where she left them in the basket, entered Resident #1's 12/10/2020 wound care orders into the computer and changed his left heel wound dressing to keep him on his schedule.

On 01/08/2021 at 1:33 PM an interview with the DON indicated she got a call at home on 12/14/2020 from Resident #1's nurse stating he was upset because his left heel wound dressing had not been changed. She stated she told the nurse to go ahead and change the dressing. The DON went on to say she didn't know at that time that his wound clinic dressing change orders had not been entered into the computer system but became aware when she called Nurse #3 that same evening to see if Nurse #3 knew anything about the situation. She stated Nurse #3 told her she received the dressing change orders for Resident #1, had forgotten to enter them into the computer, was returning to work in the morning on 12/15/2020 and would enter them then. The DON further indicated nurses should be entering physician orders into the computer on the same day they are received.

On 01/09/2021 at 8:31 PM a telephone interview with Resident #1's facility physician indicated he was not notified of any missed dressing changes for Resident #1. He stated if the order was for Resident #1 to have his dressing change done on Tuesday, Thursday and Saturday than that's what

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should have been done.

On 01/11/2021 at 10:00 AM a telephone interview with Resident #1's wound care clinic physician indicated Resident #1 had a wound clinic appointment on 12/10/2020 and his left heel wound dressing was changed. He stated as Resident #1 left the wound clinic that day with orders to change the dressing on Tuesday, Thursday and Saturday the next dressing change would have been due on Saturday 12/12/2021. He stated the risk of Resident #1 not getting his dressing change done as ordered was for a decline in the wound. He went on to say Resident #1 had no decline in his wound during that period and his wound was improving.

On 01/11/2021 at 12:00 PM in follow up interview the Administrator stated the facility medical records department had not been able to locate any paperwork from Resident #1's 12/10/2020 wound clinic appointment so there was no proof the facility received any. She went on to say Nurse #3 could have gotten the wound care orders she entered on 12/15/2020 verbally. She further indicated if there was no documentation to say Resident #1's dressing change was done on 12/12/2020 then it was not done but she did not think the facility would be responsible for a missed dressing change on 12/12/2020 if they hadn't received any orders.