STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING _____ B. WING _____	C 08/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CONCORD	515 LAKE CONCORD ROAD NE CONCORD, NC 28025

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E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 08/18/21-08/31/21. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# EHLE11	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 08/18/21-08/31/21. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. EHLE11 3 of the 9 complaint allegations were substantiated resulting in deficiencies 6 of the 9 complaint allegations were not substantiated. Substandard Quality of Care was identified at: CFR 483.25 at tag F686 at a scope and severity H A Partial extended survey was also conducted.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring	F 580		9/30/21

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

Electronically Signed | 09/17/2021

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F 580	Continued From page 1	F 580		

physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to

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F 580	Continued From page 2 room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff, nurse practitioner and physician interviews, the facility failed to notify the provider of skin assessment changes for 1 of 3 residents reviewed for pressure ulcers (Resident #1). Findings included: 1. Resident #1 was admitted to the facility on 06/24/21 with multiple diagnoses which include in part, generalized weakness, chronic obstructive pulmonary disease and heart failure. The Admission Minimum Data Set (MDS) completed on 07/01/21 indicated Resident #1 was moderately cognitively impaired. She required extensive assistance with bed mobility, dressing, toileting and transfers. No pressure ulcers were noted, and she was assessed to be at risk for pressure ulcers and no pressure reducing bed or turning program were documented. Review of the History and Physical from 06/30/21 indicated Resident #1 was admitted for rehabilitation for generalized weakness. The weekly skin check from 07/14/21 documented the skin was intact, with no redness or breakdown. Record review of the weekly skin check from 07/22/21 indicated redness was noted to her bottom.	F 580	Resident #1 no longer resides at the facility. On 9/17/21, licensed nurses completed skin assessments for sixty-two (62) current in-house residents. Residents with changes in skin condition were reported to the physician and/or nurse practitioner by the licensed nurse and follow-up orders obtained as appropriate. 9/17/21-9/27/21, the DON ,MDS Coordinator or Nurse supervisor provided education to licensed nurses including agency nurses on timely notification to the physician and/or nurse practitioner of changes in resident skin condition. Education was also provided to nurse aides including agency aides on reporting skin changes to the licensed nurse responsible for residents□ care. Newly hired licensed nurses and nurse aides will receive education during orientation. Going forward new agency staff will be educated prior to working their next schedule shift. The licensed nurse will review resident skin condition upon admission, weekly and with changes in condition. Nurse aides will complete body audits during ADL care and will promptly report skin concerns to the licensed nurse verbally, written and/or via a POC clinical alert. New skin concerns will be reported to the	

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F 580	Continued From page 3 The weekly skin check from 07/29/21 noted an area was noted to Resident #1's bottom and treatment was in place. The Nurse Practitioner (NP) note dated 07/29/21 revealed Resident #1's discharge was cancelled due to lower back and buttock pain with a scale of 10/10, and an inability to move in bed. The NP turned the resident to her side and noted a large unstageable pressure wound covering her lower back and buttock area. A phone interview was done with the Nurse Practitioner (NP) on 08/23/21 at 3:12 PM. She stated she was doing a discharge visit for Resident #1 on 07/27/21, but her discharge was cancelled due to a new pressure ulcer and her pain. She said neither the redness identified on 07/21/21 or the pressure ulcer was ever reported to her. If the redness had been reported she would have had them off load the pressure and if more than that was needed, she would have ordered a wound care consult. A phone interview was done with the Wound Doctor on 08/23/21 at 1:09 PM regarding Resident #1. He stated with the new onset of redness on 07/21/21, when they had noted it, they should have called the physician and some interventions would have been initiated The Director of Nursing (DON) was interviewed via phone on 08/23/21 at 3:47 PM. She said weekly skin checks were being done by the nurse on the hall and if new redness was noted they should tell the supervisor and they contacted the Physician. The DON stated the new onset of skin redness for Resident #1 was not reported to her and should have been.	F 580	physician and/or nurse practitioner upon findings by the licensed nurse for follow-up treatment. The DON , wound nurse or nurse supervisor will complete an audit of resident skin assessments to ensure timely notification of skin changes to the physician and/or nurse practitioner. Monitoring will be completed for five (5) random residents at a frequency of five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with notification of changes in resident condition.	

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F 580	Continued From page 4 An interview was conducted with the Corporate Director of Quality Assurance (QA) on 08/19/21 at 4:52 pm regarding wound care. She stated that the facility should have notified the Physician for preventive treatment when the redness was identified on Resident #1's bottom. An interview was held with the Administrator, Corporate Director of QA and Corporate Director on 08/19/21 at 5:20 PM. The administrator stated if new redness was noted she would expect the Physician would be notified and a plan would be put in place.	F 580		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		9/30/21

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F 657	Continued From page 5 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff, nurse practitioner and physician interviews, the facility failed to review and revise a resident's care plan to accurately reflect new redness, a pressure ulcer, and the associated treatments for 1 of 2 residents reviewed for pressure ulcers. (Resident #2) Findings included: 1. Resident #1 was admitted to the facility on 06/24/21 with multiple diagnoses which include in part, generalized weakness, chronic obstructive pulmonary disease and heart failure. The Admission Minimum Data Set (MDS) completed on 07/01/21 indicated Resident #1 was moderately cognitively impaired. She required extensive assistance with bed mobility, dressing, toileting and transfers. No pressure ulcers were noted, and she was assessed to be at risk for pressure ulcers and no pressure reducing bed or turning program were documented. The care plan for Resident #1, which was initiated on 06/24/21, contained a focus area for the potential for impaired skin integrity related to generalized weakness and decreased mobility. Interventions included to administer medications and treatments as ordered and follow	F 657	F657/SS=D Care Plan Timing and Revision Resident #1 no longer resides at the facility. On 9/17/21, licensed nurses completed skin assessments for sixty-two (62) current in-house residents. Care plans reviews and revisions completed by the Interdisciplinary Team (IDT) for residents with pressure wounds and for those at risk for pressure wound development for associated treatments and prevention. 9/17/21-9/27/21, the DON, MDS Coordinator and nurse supervisor provided education to licensed nurses including agency nurses on the review and revision of care plans for residents with actual pressure wounds and for those at risk for pressure wound development to accurately reflect treatments and preventative skin care. Newly hired licensed nurses will receive education during orientation. Going forward agency nurses will be educated prior to working next schedule shift. The licensed nurse in collaboration with the IDT, will review and revise resident actual/potential pressure wound care	

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F 657	Continued From page 6 prevention/treatment protocols for skin breakdown. The Care plan was updated on 07/30/21 under the potential for impaired skin integrity risk category with the notes of, wound to sacrum and continue treatment until healed. No new interventions specific to pressure ulcers were included at that time. The weekly skin check from 07/14/21 documented the skin was intact, with no redness or breakdown. Record review of the weekly skin check from 07/22/21 indicated redness was noted to her bottom. The weekly skin check from 07/29/21 noted an area to Resident #1's bottom and treatment was in place. The Nurse Practitioner (NP) note dated 07/29/21 revealed Resident #1's discharge was cancelled due to lower back and buttock pain with a scale of 10/10 which indicated the worst possible pain, and an inability to move in bed. The NP turned the resident to her side and noted a large unstageable pressure wound covering her lower back and buttock area. Orders were written for a wound care consult and to keep the resident off her back. Daily dressing orders were given until the resident was assessed by the wound physician. A phone interview was done with the Nurse Practitioner (NP) on 08/23/21 at 3:12 PM. She stated she was doing a discharge visit for Resident #1 on 07/27/21, but her discharge was cancelled due to a new pressure ulcer and her pain. She said neither the redness identified on	F 657	plans to accurately reflect associated treatments and prevention for residents assessed with pressure wounds and for those at risk for pressure wound development. The DON , wound nurse and or nurse supervisor will complete an audit of actual/potential pressure wound care plans for accurate review and revision for residents with assessed with skin concerns. Monitoring will be completed on five (5) random residents at a frequency of five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with care plan timing and revision.	

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F 657	Continued From page 7	F 657		

07/21/21 or the pressure ulcer was ever reported to her. If the redness had been reported she would have had them off load the pressure and if more than that was needed, she would have ordered a wound care consult.

A phone interview was done with the Wound Doctor on 08/23/21 at 1:09 PM regarding Resident #1. He stated with the new onset of redness on 07/21/21, when they had noted it, they should have called the physician and some interventions would have been initiated.

An observation was done of Resident #1's wound care on 08/18/21 at 03:10 PM. The wound was cleaned, and an antibacterial solution soaked gauze dressing was applied. The wound was pink and very large across both buttocks and the sacral area. An air mattress was on the bed.

An interview was done on 08/19/21 at 2:14 PM with MDS nurse #2 regarding Resident #1. She noted the resident was coded as being at risk for pressure ulcers, had a care plan for it and weekly skin checks. She was asked about interventions being done when the skin was reddened. She stated if it was not brought up in the daily meeting, she would not have known to update the care plan or add interventions.

An interview was done on 08/19/21 at 12:19 PM with the Supervisor responsible for Infection Prevention/Staff Development regarding wound care. She said they were trying to improve the wounds at the facility. The nurse noted every resident had a weekly skin assessment done, and residents with skin risks and wounds were discussed at the weekly risk meetings. She said all mattresses were pressure reducing mattress,

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F 657	Continued From page 8 and if a resident developed a wound, they would add the air mattress. A follow up phone interview was done on 08/28/21 at 11:33 AM with the Supervisor responsible for Infection Control/Staff Development and wound education. She was asked about updating the care plan with new skin concerns and stated it should be updated. The nurse on the unit or the supervisor should update it and notify the physician. The Supervisor noted that the MDS nurses did the majority of the care plan updates. She acknowledged that the care plan should have included the risk for pressure ulcer, and also had a focus area for an actual pressure ulcer. The treatment orders, air mattress if ordered, turning and repositioning should have been added. The Director of Nursing (DON) was interviewed via phone on 08/23/21 at 3:47 PM. Weekly skin checks were being done by the nurse on the hall and if new redness was noted they should tell the supervisor and then contact the Physician. The DON stated the new onset of skin redness for Resident #1 was not reported to her and should have been. An interview was held with the Administrator, Corporate Director of Quality Assurance (QA) and Corporate Director on 08/19/21 at 5:20 PM. The administrator stated if new redness was noted she would expect the Physician would be notified and a plan would be put in place. The Administrator said staff were to document their actions and findings.	F 657		
F 686 SS=H	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		9/30/21

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F 686	Continued From page 9 §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, record reviews and staff, nurse practitioner and physician interviews, the facility failed to assess and implement interventions to Resident #1's newly identified reddened sacral area that worsened to an unstageable wound within seven days (Resident #1) and provide evidence that wound care was completed as ordered for 2 of 2 sampled residents reviewed for pressure ulcers (Residents #1, Resident #2). This resulted in Resident #1 developing an unstageable pressure ulcer that was not treated as ordered. Findings included: 1. Resident #1 was admitted to the facility on 06/24/21 with multiple diagnoses which include in part, generalized weakness, chronic obstructive pulmonary disease, pulmonary fibrosis and heart failure. She also had Sjogrens syndrome-an autoimmune disease with lung involvement.	F 686	F686/SS=H Treatment/Services to Prevent/Heal Pressure Ulcers Resident #1 no longer resides at the facility. Resident #2 will continue to have wound treatments completed and documented on the Treatment Administration Record (TAR) as ordered. On 9/17/21, licensed nurses completed skin assessments for sixty-two (62) current in-house residents. Residents identified with skin concerns were reviewed for associated treatment orders and documentation of treatments on the TAR. The physician was notified by the licensed nurse of newly identified skin concerns and treatment orders obtained and care plan updated to reflect associated care and interventions to prevent and/or heal pressure wounds.	

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F 686	Continued From page 10 The care plan for Resident #1, which was initiated on 06/24/21, contained a focus area for the potential for impaired skin integrity related to generalized weakness and decreased mobility. Interventions included to administer medications and treatments as ordered and follow prevention/treatment protocols for skin breakdown. Bloodwork completed on 06/21/21 indicated Resident #1's albumin (protein) level was 2.5. Normal levels are 3.7-4.8. The total protein level was 4.9 with a normal range of 6.3-8.3. The Admission Minimum Data Set (MDS) completed on 07/01/21 indicated Resident #1 was moderately cognitively impaired. She required extensive assistance with bed mobility, dressing, toileting and transfers. No pressure ulcers were noted, and she was assessed to be at risk for pressure ulcers and no turning program was documented. A House Supplement was ordered 07/06/21 three times a day 240 milliliters between meals to assist with Resident #1's low protein level and poor nutritional intake. Resident #1's estimated protein daily requirements per the Dietician note was 62 grams. The weekly skin check from 07/14/21 documented the skin was intact, with no redness or breakdown. Record review of the weekly skin check from 07/22/21 completed by Nurse # 1 indicated redness was noted to her bottom. Nurse #1 documented the weekly skin check on	F 686	9/17/21-9/27/21, the DON, MDS Coordinator and or Nurse supervisor provided education to licensed nurses including agency nurses on facility guidelines for pressure ulcer prevention and management. Education includes completing resident skin assessments, notification of changes in skin condition, obtaining treatment orders, updating and revising care plans and documenting completion of treatments as ordered to prevent and heal pressure wounds. 9/17/21-9/27/21, the DON ,MDS Coordinator and Nurse Supervisor provided education to nurse aides including agency aides on facility guidelines for completing skin observations and reporting resident skin changes to supervising licensed nurse. Education includes use of Body Scan Tools and PCC Clinical Alerts to communicate skin concerns observed during ADL care. Newly hired licensed nurses and nurse aides will receive education during orientation. Going forward new agency staff will be educated prior to working their next schedule shift. The licensed nurse will complete resident skin reviews upon admission, weekly and with changes in skin condition to identify skin concerns. The nurse aide will complete skin observations during bathing and routine ADL care to identify skin concerns and communicate such findings to the licensed nurse. The licensed nurse	

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F 686	Continued From page 11 07/22/21 and was interviewed via phone on 08/27/21 at 4:38 PM. She stated she noticed redness and had applied barrier cream and always told her supervisor of skin changes. She said she had told her evening shift supervisor and the Infection Preventionist (IP)/Wound education supervisor on 7/22/21 whom told her what treatment to do. She noted they applied the barrier cream every day and would communicate that to the Nurse Aides (NAs) as well. She said the NAs knew to do the barrier cream as part of the skin protocol. The evening Supervisor #3 was interviewed via phone on 8/28/21 at 12:05 AM regarding Resident #1's pressure ulcer. She said on 7/22/21 the redness was seen on the weekly skin check and she didn't recall anyone telling her about the redness. This nurse stated she knew about the redness, but she did not recall if she had found out about it on 07/22/21. She stated all the staff knew to do the barrier cream and that was readily available in stock and in every resident's room. Resident #1 was preparing to go home, then developed the red area that was treated with barrier cream, and it progressed quickly to thick eschar on 07/29/21 and then the wound opened up. She noted some of the redness had cleared up around the perineal area but not the sacrum. She said the redness was blanchable initially and the breakdown seemed to occur very sudden. She noted Resident #1 was a very picky eater, liked fast food and would usually drink her supplements. She said the supplement ordered in July had been increased on 08/10/21. They had encouraged her to turn and to eat. An interview was done 08/28/21 at 11:33 AM with the IP/Wound Educator Supervisor regarding	F 686	will notify the physician and/or nurse practitioner of new skin concerns and implement treatments as ordered. Treatments will be completed and documented on the TAR by the licensed nurse as ordered. Care plans to prevent and/or heal pressure wounds will be initiated upon new findings and reviewed and revised by the IDT with changes in skin condition and associated treatments. Pressure and non-pressure wounds will be assessed by the licensed nurse upon finding, weekly and with changes in condition and documented in PCC on the Pressure/Non-Pressure Ulcer UDA tool. The Director of Nursing and Wound Nurse will monitor the TAR daily for completion of treatments as ordered and will monitor residents with skin concerns for compliance with pressure ulcer management and prevention during daily clinical meeting for new skin concerns and weekly during risk meetings. The DON, MDS Coordinator and or Nurse Supervisor will complete an audit of resident assessments, notification to practitioner, associated treatment orders, TAR and care plan. Monitoring will be completed on five (5) random residents at a frequency of five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with treatment to prevent and	

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Resident #1's wound 07/22/21 assessment. She stated she did not recall being told about the redness from Nurse #1 and she was usually not there on evening shift.

The Nurse Practitioner (NP) note dated 07/29/21 revealed Resident #1's planned discharge was cancelled due to lower back and buttock pain and an inability to move in bed. The NP turned the resident to her side and noted a large unstageable pressure wound covering her lower back and buttock area. Orders were written for a wound care consult and to keep the resident off her back. Daily dressing orders were given until the resident was assessed by the wound physician. The wound was to be cleaned with wound care cleanser using 4x4 gauze, patted dry, apply zinc paste and cover with foam dressing.

The weekly skin check completed on the evening shift on 07/29/21 completed by Nurse #1 documented "an area was noted to Resident #1's bottom and treatment was in place."

Nurse #1 documented the weekly skin check on the evening shift 07/29/21 and was interviewed via phone on 08/27/21 at 4:38 PM. She had also completed the 07/22/21 assessment. She stated with the 07/29/21 skin assessment, the decline had progressed so fast, and the skin was hard and black. She said she did not tell anyone as she thought they already were aware, as she was told they were waiting on the wound doctor. On the 07/29/21 assessment she did not document the size and treatment as she believed wound care had been ordered already and they were waiting on the Wound Doctor to debride it.

The Care plan was updated on 07/30/21 under

heal pressure wounds.

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the focus area for Risk for Pressure Ulcer with the notes of a wound to the sacrum, and to continue treatment until healed.

The Wound Physician note from 07/30/21 documented the wound was unstageable with 100% thick adherent black necrotic tissue and had a duration of greater than 3 days. The wound was 9 centimeters (cm) long x 10.4cm wide and the depth could not be measured. Orders for a pressure reduction air mattress, daily dressing changes, to off-load wound and reposition per facility protocol were given. The estimated time to heal was 168 days.

The NP note from 07/30/21 indicated Resident #1's white blood count was 17.7 (normal 3.6-11.7) and the resident had a newly diagnosed large sacral ulcer, and she had been less interactive.

The weekly skin check assessment from 08/06/21 noted an unstageable facility acquired pressure ulcer and it was worsening. This was documented by Supervisor #1 that conducted weekly wound rounds with the physician. The assessment noted necrotic tissue was at 60% with 40% granulation tissue present and the wound drainage was purulent. The wound measured 14.4 cm in length, 10.5 cm wide and 3 cm deep. It indicated the wound was debrided by the Wound Physician on 08/06/21 and antibacterial dressings were ordered daily. An air mattress was in place at that time.

Review of the Treatment Administration Record (TAR) from 08/01/21-08/23/21 indicated the daily dressing with an antibacterial solution was not documented as being completed on the weekend of 08/07/21 or 08/08/21.

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Nurse #3, the assigned nurse for Resident #1 on day shift 08/07/21 was interviewed on 08/19/21 at 3:46 PM regarding Resident #1's wound dressing. She was asked if the wound care was completed and said she probably completed the dressing and had not signed it off. When asked what type of dressing she did, the description was not the ordered treatment and she could not recall the wound appearance. She then added she did not usually work that unit and she was busy administering medications, and someone came in to do treatments that day, but the dressing never got done. When asked about Resident #1's wound she said it was improving. The nurse said it had been an issue with staffing to get treatments done since COVID hit and there had been consistent problems, and weekends were worse. The assignment sheet was reviewed, and this nurse was assigned to Resident #1 several shifts.

A phone interview was conducted on 08/24/21 at 12:14 PM with Agency Nurse #2 that was assigned to Resident #1 on 08/08/21 on dayshift. She did not recall completing the wound care on Resident #1. She said there was no treatment nurse, and she was assigned treatments and medications for her residents.

Review of the Wound Physician note on 08/13/21 indicated the sacral wound was measured at 12 cm long x 12.5 cm wide x 3.3 cm deep. Wound progress was documented as improved.

The evening Supervisor #3 was interviewed via phone on 8/28/21 at 12:05 AM regarding Resident #1's pressure ulcer. She said the supplement ordered in July had been increased

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on 08/10/21. They had encouraged her to turn and to eat. The Supervisor indicated the Wound Physician saw her and debrided the wound 08/06/21 and by 08/13/21 it had decreased in size.

A nursing note from 08/17/21 at 04:03 PM indicated Resident #1 screamed in pain when range of motion was completed following a fall, due to the stage 4 sacral ulcer.

Resident #1 was observed on 08/18/21 at 09:30 AM. She was positioned on her left side, resting in bed with eyes closed and was on continuous oxygen via nasal cannula.

An observation was done of Resident #1 on 08/18/21 at 12:12 PM. She remained positioned on her left side as she had been that morning. An interview with Resident #1 was attempted on 08/18/21 at 12:12 PM. She opened her eyes to voice and answered some questions but was not understandable. She was grimacing and had no response when asked if she had pain. An observation was done of Resident #1 on 08/18/21 at 3:09 PM, and she was still positioned on her left side.

An interview was done on 08/18/21 at 09:10 AM with the Nursing Supervisor/Wound Care Nurse. She stated a nurse was assigned today to do treatments. An interview was done with Agency Nurse #1 on 08/18/21 at 09:30 AM regarding Resident #1's dressing. She said she was not able to do treatments on 8/18/21 as planned because of staffing and she was 3 hours late starting on the medication cart. The nurse stated she was assigned to do treatments and when a nurse did not show she was assigned to give

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medications and she had just been told of the change. An interview was done with Agency Nurse #1 on 08/18/21 at 12:30 regarding Resident #1's dressing. The nurse said she would see if another nurse would do Resident #1's dressing as she had many more medications to do.

An observation was done of Resident #1's wound care on 08/18/21 at 03:10 PM. The resident was turned more on her side and hollered out in pain frequently during the dressing change. The resident had been medicated about 1:30 PM Agency Nurse #1 stated. The wound was cleaned, and an antibacterial solution soaked gauze dressing was applied. The wound was pink and very large across both buttocks and the sacral area. An air mattress was on the bed. An interview was done on 08/18/21 at 3:33 PM with Agency Nurse #1. She was asked if Resident #1 had been turned today and stated, "I am not 100% sure."

An interview was completed on 08/19/21 at 11:03 AM with Nurse Aide (NA) #1 who worked with Resident #1 on 08/18/21. She noted she had worked with Resident #1 since admission, and she used to be more alert and walked with help. She said she would get someone to help turn her due to the resident's pain. The NA said she cared for Resident #1 on 08/18/21 and had turned her to the right about 07:30 AM and to the left toward door at 11:00 AM. She said she was not positioned on her back and would be turned every 2 hours.

A follow-up phone interview was done on 08/28/21 at 3:19 PM with NA #1 about Resident #1. She said initially after her 2 weeks of

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quarantine and moving the B hall, her appetite was good. The NA stated then she got sick with her knee swelling, and in less than a week she had the pressure ulcer. She said she had started to complain of knee pain when she was laying in the bed and did not want to move. Her sacral area had one little dark spot and another one was a little bigger, and she reported it to her charge nurse which she believed was an agency nurse. She was told to put barrier cream on it, and at the end of her shift she also told the Director of Nursing. She thought it was three days later a dressing was on it. She had tried to reposition her every 2 hours in the bed, 2-3 times a day. She noted Resident #1 used to get up and sit in her wheelchair for 2-3 hours, but once her knee swelled, she would not get out of bed.

A follow-up call with the Director of Nursing was done on 08/28/21 at 3:49 PM. She was asked if NA #1 had reported the black area on Resident #1 when it was first noticed to her. She said she thought she had first found out about the blackened area by the Nurse Practitioner and was not told by an NA.

A phone interview was done on 08/27/21 at 4:20 PM with NA #4. She noted Resident #1, who was African American, that her skin was darker on her bottom and she had informed her nurse and the charge nurse, who stated she was going to do a treatment for it. NA #4 did not recall the date she had informed them but stated she had cared for her on several shifts. She stated she never saw changes in her skin other than the darkness and she was in pain, and then the second time it was black, and the skin was changing color around it. The NA noted they always had a barrier cream for the redness, turned her every two hours and put a

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pillow between her legs. She said Resident #1 would not eat at all and refused her meals.

An interview was done at 08/19/21 at 11:30 AM with Agency Nurse #1 about Resident #1. She was not in her room and the nurse stated that they sent her to the hospital mid-morning due to a low grade fever and vomiting.

Review of the hospital records from Resident #1's 08/20/21-08/26/21 admission indicated the sacral wound did not show sign of acute infection. The wound was pink without purulent drainage and a wound vac was placed. She was treated with an antibiotic specific to a urinary tract infection (UTI). She was to follow up with the wound care clinic at discharge.

An interview with the MDS coordinator was done on 08/18/21 at 08:45 AM regarding wound care. She stated they had not had a wound nurse in several months.

Nurse #1 was interviewed on 08/19/21 at 3:30 PM regarding wound care and missed documentation of wound care. She was assigned to Resident #1 on 08/07/21 and 08/08/21. She worked evenings and said if wound care was not done on days, the day nurse had not always relayed the treatments that still needed to be done. She said she would have completed treatments if she had known they weren't done. She said previously, there was a treatment nurse at times on days that could do the wound care but not now due to staffing.

A phone interview was done with Nurse #4 at 5:45 PM on 08/23/21 regarding wound care. She noted she had Resident #1 initially on admission for several shifts, but she had no skin issues at

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that time. She said they had been working with 2 nurses each shift for a while, and the Infection Prevention nurse and the 2 MDS nurses took turns helping with wounds. She said on Saturday there may be a treatment nurse but on Sundays the treatments were left up to the two nurses with 60+ residents. She said weekly skin checks were assigned to someone else but not the nurse on the floor. She stated if she was told of new redness, she would have paged the doctor or the NP for orders. The nurse said they had a skin care protocol they could initiate with application of skin prep on the heels or coccyx or to use barrier cream. The protocol did not need an order. She added with new redness, she would tell the NAs in report and put a pillow under the hip if the resident did not want to turn on their side completely. She stated with the pandemic, staffing was short.

The Registered Dietician was interviewed on 08/27/21 at 1:33 PM and stated she reviewed all new admissions and followed them monthly for wound care needs. Resident #1 was seen on 07/06/21 and she ordered supplements as her meal consumption was documented anywhere from 0-75% and her family was bringing in some food. She stated most meals were 50% or less. The dietician stated she followed up for Resident #1's wound care nutritional needs on 08/10/21 and her intake was 0-25 %. She had increased her supplement at that time to 240 ml three times a day. Her estimated protein needs for wound healing had increased to 92 grams.

Bloodwork completed on 08/19/21 for Resident #1 indicated her protein level was 2.6. Normal level was 3.7-4.8. The total protein was 6.4 with a normal range of 6.3-8.3.

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A phone interview was done with the Nurse Practitioner (NP) on 08/23/21 at 3:12 PM. She stated she was doing a discharge visit for Resident #1 on 07/27/21, but her discharge was cancelled due to a new pressure ulcer and her pain. She said neither the redness identified on 07/22/21 or the pressure ulcer was ever reported to her. If the redness had been reported she would have had them off load the pressure and if more than that was needed, she would have ordered a wound care consult. She said her dressings should be done daily as ordered. She said there had been chronic issues with the orders for dressings. She said there was no follow up from nursing once she asked about it. She said after discussing with the nurses responsible for care and no improvement she went to the Administrator over a month ago. She noted an improvement since that time.

A phone interview was done with the Wound Doctor on 08/23/21 at 1:09 PM regarding Resident #1. He stated with the new onset of redness on 07/22/21, when they had noted it, they should have called the physician and some interventions would have been initiated. He said her wound required debriding multiple times and with the current treatment, the wound was looking better. The Physician said the last assessment noted 80% good tissue and 20% necrotic tissue. He said he expected the orders for dressing changes to be followed.

A follow up phone interview was conducted with the Wound Doctor on 08/27/21 at 11:09 AM. He was asked if the pressure ulcer could have been avoided and he stated this was hard to say, as she had several other issues that would

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contribute to skin breakdown. He said there was not a clear yes or no. He noted her age, being immunocompromised and in a poor nutritional state contributed to her muscle mass decreasing. The Wound Doctor stated she had lost subcutaneous fat with not eating well, which led to not much between her skin and bone, and that would send off a cascade of events. She had decreased mobility and with several negative factors going against her, she was at a much higher risk. He said he was called in after the breakdown so he could not comment on the redness or the timeframe to skin breakdown. The physician added Resident #1 may have been at the tipping point, and being in long term care, showed she was declining in status, was closer to end of life, had failing faculties cognitively and her protein level was off with the poor nutrition.

An interview was done on 08/19/21 at 12:19 PM with the Supervisor responsible for Infection Prevention/Staff Development/Scheduling regarding wound care. She said she had rounded with the wound doctor on Fridays since she started the end of February, and there was no wound nurse since that time. She said the nurses did the treatments and depending on the staffing, they would schedule a treatment nurse. If they were short staffed, either she or the MDS nurse would help with treatments. She said they were trying to improve the wounds at the facility. She stated 99% of the time she did the treatments on Friday with wound rounds, or if the resident was soiled the assigned nurse would complete it. The nurse noted every resident had a weekly skin assessment done, and residents with skin risks were discussed at the weekly risk meetings. They also discussed wounds, infections, new admissions and indwelling

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catheters. She said if it was determined a resident was high risk at the risk meeting, they would discuss it with the Nurse Practitioner or Physician. She said all mattresses were the pressure reducing mattress, and if a resident developed a wound, they would add the air mattress.

A follow-up interview was done with Supervisor #1 regarding Resident #1's wound on 08/28/21 at 11:33 AM. She noted the resident initially had been up in the wheelchair frequently, and then was not eating at one point. When asked about the wound she stated the NAs doing incontinence care and bathing should have reported the skin changes. She said she was still in therapy preparing to go home but the wound progressed in about 2 days. She stated the wound had improved significantly. The wound went from eschar and black the first week, then the second week the Wound Doctor debrided it, and third week the area was very clean, and it had decreased in size. She also noted that during her recent hospital stay 08/19/21-08/26/21, they had been following with the hospital team and were told the hospitalists had said the wound was very clean and healing.

The Director of Nursing (DON) was interviewed via phone on 08/23/21 at 3:47 PM. She said they had noticed several times that wound care was not documented, and the Infection Prevention (IP) nurse had conducted a treatment documentation audit recently. The DON did not recall when it was done. She said the IP nurse was usually rounding and doing treatments with the wound Doctor 1 day a week and the MDS nurses were doing treatments three days a week. The other days, the assigned nurse was to complete wound

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care and treatments. She said she had no extra staff to assign a treatment nurse to do wound care and treatments. She said the nurses were aware of the days the treatments would be done by other staff. She said the agencies couldn't provide needed staff and they don't have facility staff to fill the slots. She said the nurses were administering medications and were expected to do treatments, if they couldn't get to it, they need to do the treatments on 2nd shift. Weekly skin checks were being done by the nurse on the hall and if new redness was noted they should tell the supervisor and they contacted the Physician. The DON stated the new onset of skin redness for Resident #1 was not reported to her and should have been.

An interview was conducted with the Corporate Director of Quality Assurance (QA) on 08/19/21 at 4:52 pm regarding wound care. She stated she had reviewed the documentation and noted the omissions. She said she had seen missing documentation frequently when facilities had agency nurses and this facility had a lot. She stated that the facility should have notified the Physician for preventive treatment when the redness was identified on Resident #1's bottom and staff should document the administration of treatments as ordered by the doctor.

An interview was held with the Administrator, Corporate Director of QA and Corporate Director on 08/19/21 at 5:20 PM. The administrator stated if new redness was noted she would expect the Physician would be notified and a plan would be put in place. The Administrator said treatments that were ordered should be followed, the Physician directions were to be done and staff were to document their actions and findings.

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2. Resident #2 was admitted to the facility on 08/07/20.

The diagnoses for Resident #2 included in part, ulcerative colitis, hypertension, history of COVID 19 and neurogenic bladder.

The care plan for Resident #2 initiated on 08/10/20 included a focus area for pressure ulcer development. Wounds to the right sacrum and right gluteus were noted and the care plan was last updated on 07/13/21.

Review of the Wound Care Physician note from 09/17/20 indicated Resident #2 had a sacral ulcer for at least 6 days duration.

A physician order for Resident #2 was written on 04/08/21 to cleanse the right sacral wound with normal saline or wound cleanser prior to applying the new dressing and as needed. Apply vacuum-assisted closure device at 125 millimeters of mercury (mm Hg) with black foam, bridge to right hip, and transparent semipermeable cover dressing. Change 3 times weekly and PRN. It was updated on 04/13/21 to change twice weekly and the order was discontinued on 06/12/21.

Review of the Treatment Administration Record (TAR) from 05/01/21-05/31/21 indicated the wound Vacuum Assisted Closure (vac) dressing ordered to be changed 2x weekly was not documented as being completed on 05/11/21 or 05/25/21. The wound vac suction cannister was ordered to be changed weekly and was not documented as being completed on 05/24/21. The wound vac monitoring was not documented

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as being completed each shift on 05/01/21, 05/02/21, 05/08/21, 05/10/21, 05/11/21, 05/15/21, 05/22/21-05/24/21 or 05/29/21-05/30/21. Several attempts were made to contact the assigned staff and agency nurses that cared for the resident without success.

Review of the Treatment Administration Record (TAR) from 06/01/21-06/30/21 indicated the wound vac monitoring ordered each shift was not documented as being completed on 06/01, 06/04/21, 06/05/21, 06/06/21, 06/08/21 or 06/12/21.

The physician wound notes from 06/18/21 noted the right sacral ulcer was 3.3 long x 5.7cm wide x 1.7 cm deep with 20% necrotic tissue and 80% granulation tissue.

Review of the NP note from 06/18/21 stated that the Stage 4 pressure ulcer was healing per the wound doctor and was improved. The resident was sent to the Emergency Department to rule out fistula with purulent urethral drainage.

The hospital records were reviewed for 06/18-21-06/23/21 and indicated she was treated for a urinary tract infection (UTI), bladder infection and sepsis. Review of a radiology report from 06/18/21 revealed a fistula was ruled out, and possible sacral osteomyelitis. The resident was placed on antibiotics to treat the UTI, bladder infection and possible osteomyelitis, which were continued for 28 days upon her return to the facility. At discharge, the resident was to follow up at the hospital's wound care clinic.

The Annual Minimum Data Set completed on 06/30/21 indicated the resident had moderately

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impaired cognition. The skin assessment indicated she was at risk for pressure ulcers, had a pressure reducing device on the bed and she had a Stage 4 wound on the right sacrum. She required extensive assistance with bed mobility and dressing and was total dependence for bathing and transfers.

An order for an antimicrobial wound cleanser to sacrum was ordered daily was written on 06/24/21 and not documented as being completed on the Treatment Administration Record (TAR) on 07/02/21, 07/05/21, 07/09/21, 07/13/21, 07/16/21-07/18/21, 07/27/21, 07/29/21-07/30/21.

Review of the initial wound clinic note from 07/12/21 indicated Resident #2 had a right gluteal ulcer and sacral ulcer that began approximately in January 2021. The sacral wound was stage 4, 1.7 centimeters (cm) long x 3.5cm wide x 2.5 deep with a small amount of necrotic tissue. The gluteal wound was stage 3, 0.4cm long x 1.1cm wide x 0.1cm deep with a large amount of necrotic tissue.

Review of the Wound clinic note from 07/26/21 indicated the gluteal wound had healed since the previous visit 2 weeks ago and the sacral ulcer had improved.

Review of the Treatment Administration Record (TAR) from 08/01/21-08/24/21 indicated the right gluteus daily wound care was not documented as being completed on 08/05/21-08/08/21 or 08/10/21-08/11/21. The sacral/coccyx wound care ordered daily was not completed on 08/05/21-08/08/21 or 08/10/21-08/11/21.

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The Wound clinic note from 08/23/21 documented that the gluteal wound remained healed, and the sacral ulcer had improved since the previous visit.

A phone interview was done with Nurse #4 at 05:45 PM on 08/23/21 regarding wound care. She was assigned to Resident #2 for 6 dates when the wound care was not documented. She said they had been working with 2 nurses each shift for a while, and the Infection Prevention nurse and the 2 MDS nurses took turns helping with wounds. She said on Saturday there may be a treatment nurse but on Sundays the treatments were left up to the two nurses with 60+ residents. She did not recall if the treatments had been completed. She stated with the pandemic, staffing was short and that was bad for Pressure Ulcer (PU) care.

A phone interview was conducted on 8/24/21 at 12:14 PM with Agency Nurse #2 and stated she did not recall completing the wound care on Resident #2 on 08/08/21.

Multiple attempts were made to call facility and agency nurses that cared for Resident #2 and failed to document completion of wound care without return calls.

A phone interview was done on 08/27/21 at 04:20 PM with NA #4 regarding Resident #2. She stated she would turn with help, and her appetite wasn't good but the past few weeks she has been doing better. She said her wound was getting better and on occasion she would get up out of bed.

An interview was done with the IP nurse/supervisor on 08/19/21 at 12:19 PM. She

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said she had been doing the wound rounds with the physician on Friday. She did Friday treatments unless the resident was soiled, then the care nurse completed it. There was no wound nurse at the facility since she started in February 2021. The nurses did the treatments usually depending on the staffing, and would try and schedule a treatment nurse, however if they were short the 2 MDS nurses helped. She said they were trying to improve the wounds. Every resident had a weekly skin assessment done, and skin risks were discussed at the weekly risk meetings. They also discussed wounds, infections, new admissions and indwelling catheters. If residents were determined to be high risk, they discussed it with the NP or physician. All mattresses were pressure reduction mattress, and if residents developed a wound, they added the air mattress. The supervisor said Resident #2's wound had decreased in size.

A follow-up interview was done with the IP nurse/supervisor regarding Resident #2. She stated the resident had a Stage 4 pressure ulcer in February and was in and out of the hospital frequently post COVID. During one of the hospital stays, they ordered a wound vac and were changing it twice a week at the facility. She noted the resident had frequent bouts of diarrhea with the ulcerative colitis and they would have to change the wound vac to gauze dressings. She stated the wound continued to heal with the wound vac and they eventually changed her to antibacterial soaked gauze. The last time she saw the wound in June it was very small and clean and 100% better compared to what it was. She said she was wound certified and had completed education with staff since she started in February 2021 on wound care and wound

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vacs.

A phone interview was conducted with the dietician on 08/27/21 at 1:33 PM regarding Resident #2. She stated she saw her monthly for her wound care needs. She noted in March, she saw her for a readmission review and at that time being post COVID, she had increased her supplements. In July, she added a dissolvable protein supplement and a frozen nutritional treat. On 08/10/21, she saw her and noted she had followed her for weight loss previously and the wounds. Resident #2 had a 16% loss in 6 months and an 11% in 3 months, and the dietician stated she was more stable now.

A phone interview was done with the Nurse Practitioner (NP) on 08/23/21 at 3:12 PM. She was asked about Resident #2 and stated the resident was going to the wound care clinic now. She said there had been chronic issues with the orders for her dressings and the wound VAC not being on. She said gauze dressings would be on sporadically instead of the wound VAC. She said there was no follow up once she asked about it. She said after discussing with the nurses responsible for her care and seeing no improvement, she went to the Administrator over a month ago. She stated she noted an improvement since that time with wound care.

A phone interview was done with the Wound Doctor on 08/23/21 at 1:09 PM regarding Resident #2. He stated he followed her for several months and in July the family wanted her care switched to the wound clinic. He said when the wound VAC was ordered, they would have periods where they had it on and off. At times a gauze dressing was on. The wound started

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looking bad as stool would get in it and he switched the order to an antibacterial solution.

A follow up phone interview was conducted with the Wound Doctor on 08/27/21 at 11:09 AM about Resident #2. He stated he had been following her for a while since she had COVID. He said in June she was sent out to the hospital and when she came back, she was set up with the hospital wound care clinic. The Physician noted when a resident had COVID, it interfered with the skin healing and the immunosuppression even cause healed wounds to break down. He noted Resident #2 had a lot of co-morbidities and the ulcerative colitis and COVID contributed. Her wounds were improving, but she had slow healing. He commented that the sacral ulcer was large and nasty initially and was definitely better. The Wound Physician noted for Resident #2 the wounds were unavoidable with COVID, poor nutrition and her disease process and would take a long time to heal.

The wound care center nurse was interviewed via phone on 8/24/21 at 9:12 AM. They stated Resident #2 was initially seen at the clinic on 07/12/21 and had two additional follow up appointments since that time. Her wounds had improved since she started treatment 07/12/21. She said Resident #2 had wounds since January when she was acutely ill, and her June scan showed possible osteomyelitis.

The Director of Nursing (DON) was interviewed via phone on 08/23/21 at 3:47 PM. She said they had noticed several times that wound care was not documented, and the IP nurse had done a treatment documentation audit recently. The DON did not recall when it was done. She said

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the IP nurse was usually rounding with the wound Doctor 1 day a week and the MDS nurses were doing three days a week. The other days, the assigned nurse was to complete wound care and treatments. She said she had no extra staff to do wound care and treatments. She said the nurses were aware of the days the dressings would be done by other staff. She said if she had 3 nurses working, they were all on a medication cart, and was rare to have 4 nurses. She said the agencies couldn't provide staff and they didn't have facility staff to fill the slots. She said the nurses were on the medication carts and were expected to do treatments, and if they couldn't get to it, they needed to do them on 2nd shift. She was asked about Resident #2 and the wound VAC dressing not being changed. The DON said at one point there was an order if the wound VAC was not functioning and the staff did not know how to fix it, to apply a dressing until someone there could fix it. She said before recent training was completed, they had only had 3 nurses that were able to change wound VAC dressings.

An interview was conducted with the Corporate Director of Quality Assurance (QA) on 08/19/21 at 4:52 pm regarding wound care documentation. She noted Resident #2 previously had orders for the wound vac and now had daily dressing changes. She noted the omissions in wound care documentation and stated she had seen missing documentation frequently when facilities had agency nurses and this facility had a lot. She stated that the staff should document the administration of treatments as ordered by the doctor.

An interview was held with the Administrator, Corporate Director of QA and Corporate Director

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F 686	Continued From page 32 on 08/19/21 at 5:20 PM. The Administrator said treatments that were ordered should be followed, the Physician directions were to be done and staff were to document their actions and findings.	F 686		
F 725 SS=H	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff and Nurse Practitioner interviews the facility failed	F 725	F725/SS=H Sufficient Nursing Staff Resident #1 no longer resides at the	9/30/21

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F 725	Continued From page 33 to provide sufficient nursing staff to identify new wounds and provide evidence of treatments provided as ordered for pressure ulcers for 2 of 2 sampled residents reviewed for pressure ulcers (Residents #1, Resident #2). Findings included: This tag is cross referenced to F686 Treatment of Pressure Ulcers: F686 Based on observations, record reviews and staff, nurse practitioner and physician interviews, the facility failed to assess and identify a new sacral wound (Resident #1) and complete and document wound care as ordered for 2 of 2 sampled residents reviewed for pressure ulcers (Residents #1, Resident #2). An interview with the MDS coordinator was done on 08/18/21 at 08:45 AM regarding wound care. She stated they had not had a wound nurse in several months. An interview was done with Agency Nurse #1 on 08/18/21 at 09:30 AM regarding Resident #1's dressing. She said she was not able to do treatments today as planned because of staffing and she was 3 hours late starting on the med cart. The nurse stated she was assigned to do treatments and when a nurse did not show she was assigned to give medications and she had just been informed of the change. A phone interview was done with Nurse #4 at 5:45 PM on 08/23/21 regarding wound care. She said they had been working with 2 nurses each shift for a while, and the Infection Prevention nurse and the 2 MDS nurses took turns helping	F 725	facility. Resident #2 will continue to have wound treatments completed and documented on the Treatment Administration Record (TAR) as ordered. On 9/17/21, licensed nurses completed skin assessments for sixty-two (62) current in-house residents. Residents identified with skin concerns were reviewed for associated treatment orders and documentation of treatments on the TAR as ordered. The physician was notified by the licensed nurse of newly identified skin concerns and treatment orders obtained and care plan updated to reflect associated care and interventions to prevent and/or heal pressure wounds. 9/17/21-9/27/21, the DON, MDS Coordinator and or Nurse Supervisor provided education to licensed nurses on facility guidelines for pressure ulcer prevention and management. Education includes completing resident skin assessments, practitioner notification of changes in skin condition, obtaining treatment orders, updating and revising care plans and documenting completion of treatments as ordered to prevent and heal pressure wounds. 9/17/21-9/27/21, the DON and MDS Coordinator provided education to nurse aides on facility guidelines for completing skin observations and reporting resident skin changes to supervising licensed nurse. Education includes use of Body Scan Tools and PCC Clinical Alerts to communicate skin concerns observed during ADL care. Newly hired licensed	

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F 725	Continued From page 34 with wounds. She said on Saturday there may be a treatment nurse but on Sundays the treatments were left up to the two nurses with 60+ residents. She stated with the pandemic, staffing was short and that was bad for Pressure Ulcer (PU) care. An interview was done on 08/19/21 at 12:19 PM with the Supervisor responsible for Infection Prevention/Staff Development/Scheduling regarding wound care. If they were short staffed, either she or the MDS nurse would help with treatments. She said they were trying to improve the wounds at the facility. The Director of Nursing (DON) was interviewed via phone on 08/23/21 at 3:47 PM. She said they had noticed several times that wound care was not documented, and the IP nurse had conducted a treatment documentation audit recently. She said she had no extra staff to assign a treatment nurse to do wound care and treatments. She said the agencies couldn't provide needed staff and they don't have facility staff to fill the slots. She noted she and other facility staff were often filling in for medication administration and nursing needs. An interview was held with the Administrator, Corporate Director of QA and Corporate Director on 08/19/21 at 5:20 PM. The administrator stated staffing had been a concern for several months with the pandemic.	F 725	nurses and nurse aides will receive education during orientation. The licensed nurse will complete resident skin reviews upon admission, weekly and with changes in skin condition to identify skin concerns. The nurse aide will complete skin observations during bathing and routine ADL care to identify skin concerns and communicate such findings to the licensed nurse. The licensed nurse will notify the physician and/or nurse practitioner of new skin concerns and implement treatments as ordered. Treatments will be documented on the TAR by the licensed nurse as ordered. Care plans to prevent and/or heal pressure wounds will initiated upon new findings and reviewed and revised by the IDT with changes in skin condition and associated treatments. Pressure and non-pressure wounds will be assessed by the licensed nurse upon finding, weekly and with changes in condition and documented in PCC on the Pressure/Non-Pressure Ulcer UDA tool. The Director of Nursing and Wound Nurse will monitor the TAR daily for completion of treatments as ordered and will monitor residents with skin concerns for compliance with pressure ulcer management and prevention during daily clinical meeting for new skin concerns and weekly during risk meetings. To support sufficient nurse staffing to prevent and heal pressure wounds, the facility has hired a new full-time wound nurse beginning 9/21/21 and a weekend	

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F 725	Continued From page 35	F 725	supervisor who will be responsible for assisting staff nurses in completing wound assessments and treatments. The wound nurse will also be responsible for monitoring resident wounds by conducting weekly wound rounds with the wound practitioner, completing weekly Pressure/Non-Pressure Ulcer assessments, maintaining an updated wound log and participating in daily clinical meeting and weekly risk meetings. The DON , MDS Coordinator , Nurse Supervisor and or wound nurse will complete an audit of resident assessments, associated treatment orders, TAR and care plan. Monitoring will be completed on five (5) random residents at a frequency of five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with sufficient nursing staff	