STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

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E 000	Initial Comments An unannounced Recertification and complaint investigation survey was conducted on 8/30/21 through 9/2/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #EVGH11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 8/30/21 through 9/2/21. Event ID# EVGH11. Three of the three complaint allegations were not substantiated.	F 000		
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 observations, record review, and staff interview the facility failed to transcribe a treatment order for 1 of 2 residents reviewed for pressure ulcers (Resident #58).	F 686	This plan of correction is submitted as required under Federal and State Regulation and statutes applicable to long term care providers. This plan of correction does not constitute an	9/21/21

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

Electronically Signed | 09/17/2021

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F 686	Continued From page 1 The findings included: Resident #58 was readmitted to the facility on 5/28/21 with diagnoses which included right sided paralysis, generalized weakness, contractures, stroke, adult failure to thrive, dementia, and abnormal posture. Review of the quarterly Minimum Data Set (MDS) dated 8/10/21 indicated Resident #58 was rarely/never understood which indicated the resident had severely impaired cognition and required total assistance one to two people with all activities of daily living (ADLs). The MDS further indicated that the resident had an unstageable ulcer due to slough and/or eschar: known but not stageable due to coverage of wound bed by slough and/or eschar. Resident #58's care plan, which was most recently updated on 8/24/21, contained a focus area which documented the resident had actual impaired skin integrity to the right plantar (bottom) foot callous and the date initiated for the care plan was 5/24/21. Review of the August Treatment Administration Record (TAR) for Resident #58 revealed an ordered application of collagenase, cover, and wrap every day until healed, every day shift for wound treatment. The order had a start date of 8/17/21 and a discontinued date of 8/27/21. The treatment was documented as having been provided on 8/17/21 and 8/19/21 through 8/27/21. The treatment was not signed off has having been completed on 8/18/21. Resident #58 was seen by the wound doctor on 8/23/21 at the facility. Review of the Wound	F 686	agreement by the facility and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' finding or conclusion are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied. F686 1. Resident #58 treatment was completed as ordered by the physician. Discontinuation of the previous order in PointClickCare was completed and corrected treatment order was entered on 9/2/21. The treatment nurse documented that the treatment was completed. 2. All resident with orders for wound care have the potential to be affected if the most current treatment is not completed as ordered. An audit of all treatment orders has been conducted on 9/6/21. There was no further deficient practice. 3. Education was provided to the treatment nurse for transcribing and placement of treatment orders in PointClickCare was provided the Director of Nursing on 9/1/21. The Staff Development Coordinator provided education to all licensed staff for placing physician treatment orders in PointClickCare on 9/1/21. Education will be provided to all new licensed staff upon hire. 4. The Director of Nursing/ designee will conduct an audit 5 x□s weekly for 2 weeks, then will conduct audits 2 times weekly for 2 weeks and then 2 times	

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F 686	Continued From page 2 Evaluation & Management Summary revealed there was an order to discontinue the collagenase treatment and to initiate a daily treatment with Leptospermum Honey to the resident right, distal (father away from the trunk of the body), lateral (to the outside of body from the centerline) foot. Another review of Resident #58's August TAR review revealed an ordered application of collagenase, cover, and wrap every day until healed to the right distal foot every day shift for wound treatment. The order had a start date of 8/28/21. The treatment was documented as having been provided on 8/28/21 and 8/29/21 and was signed off as completed by the Wound Nurse (WN). Review of the August TAR revealed no evidence of the Leptospermum Honey order. The treatment was not signed off has having been completed on 8/30/21 and 8/31/21. Resident #58 was seen by the wound doctor on 8/30/21 at the facility. Review of the Wound Evaluation & Management Summary revealed there was an order to continue the daily treatment with Leptospermum Honey to the resident right, distal, lateral foot. During an interview and observation conducted with the Wound Nurse (WN) on 8/31/21 at 10:20 AM she stated she was going to enter the new treatment into the TAR of the electronic medical record (EMR) for Resident #58. She was then observed working on the computer on top of her treatment cart. She said she wanted to get the order in before providing the treatment. She said she was writing a new order for a Leptospermum honey treatment to be applied daily. An observation was conducted on 8/31/21 at	F 686	monthly for 2 months. All findings of the audits will be reviewed in QAPI monthly. The findings from audits conducted for transcription of treatment orders will be review in Quality Assurance meeting . The Interdisciplinary Team will discuss findings and make changes as needed to ensure compliance is met.	

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F 686	Continued From page 3 10:26 AM of the WN applying Leptospermum honey to Resident #58's right, distal, lateral foot. An interview was conducted on 9/1/21 at 1:47 PM with the WN. She stated she had entered the Leptospermum honey treatment order yesterday for Resident #58, but it had a start date for 9/1/21. She said the treatment in the TAR for August was still collagenase, but she had applied Leptospermum honey as ordered as of 8/23/21 and had continued to apply the treatment up through 8/31/21. She said she had thought the wound doctor had updated the order in the TAR, but she learned he did not. She explained it was her misunderstanding. She further stated she had not looked closely at the treatment order in the TAR, which was for collagenase, and thought she had signed off the Leptospermum treatment as applied. She said she would need to more closely review the TAR to confirm the treatment in the TAR was correct and to verify she was applying the correct ordered treatment. The nurse who had signed off for the treatment on 8/27/21 was unable to be interviewed. The DON was interviewed, in the presence of the Administrator, on 9/1/21 at 4:33 PM. The DON stated the WN was new, and she was doing very well but was not familiar with how the EMR worked. She explained she would work with and be sure not only the new WN but also the other new nursing staff were trained on how to properly enter orders into the EMR. She said she had already talked with the new WN and provided resources for her regarding the EMR.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		9/21/21

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F 688	Continued From page 4 §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to apply a left elbow splint for 1 of 3 residents reviewed with limited range of motion (Resident #58). The findings included: Resident #58 was readmitted to the facility on 5/28/21 with diagnoses which included right sided paralysis, generalized weakness, contractures, stroke, adult failure to thrive, dementia, and abnormal posture. Review of the August Medication Administration Record (MAR) for Resident #58 revealed an ordered application of a left elbow splint. The resident was to wear it for 3-4 hours daily during day shift for contractures with a start date of	F 688	F688 1. Resident #58 was evaluated by therapy for the proper splinting device to the left elbow. The therapist at approximately 1400 provided passive range of motion, assessed the skin and then applied the elbow splint. The surveyor was present during this process on day two of survey (8/31/21) The nursing staff followed the recommended hours of wear and removed the splint at 1800 and assessed the skin and there were no abnormalities noted 2. All resident with orders for splinting devices has the potential to be affected by not applying the splinting device as	

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F 688	Continued From page 5 6/26/21. The splint was documented as having been applied from 8/1/21 through 8/22/21, 8/25/21, 8/27/21 through 8/29/21, and 8/31/21. 8/23/21, 8/24/21, 8/26/21, and 8/31/21 was coded to indicate other/see nurse notes. Review of the quarterly Minimum Data Set (MDS) dated 8/10/21 indicated Resident #58 was rarely/never understood which indicated the resident had severely impaired cognition and required total assistance one to two people with all activities of daily living (ADLs). The MDS further indicated that the resident had functional limitation in range of motion (ROM) of the upper extremity (shoulder, elbow, wrist, hand) on one side. Resident #58 ' s care plan, which was most recently updated on 8/24/21, contained a focus area which documented the resident was dependent for ADL care due to impaired mobility related to right side hemiplegia, contracture to bilateral hands and left elbow, impaired communication due to aphasia. There was another focus area detailing the resident required application of splints to the left elbow, bilateral palm shields for contractures management, hip abductor between legs while up in wheelchair, pillow between legs while in bed, and wedge to her right side to prevent twisting and rotation and the date initiated was 6/20/20. The goal was for the resident to have no complications related to use of splints daily through next review. The interventions included: Left elbow splint wear for 3-4 hours daily skin checks prior and after wearing. An observation of Resident #58 was made on 08/30/21 at 12:34 PM. The resident was resting	F 688	ordered. 100% of residents with splinting device orders have been review for the proper splinting device with recommended wear times. Each of the residents with splint device orders will be evaluated by the therapy department to ensure the device is current to the residents needs. All orders will include site and application times. All care plans will be review and revisions will be made as necessary. 3. Staff education was provided by the Staff Development Coordinator to all Rehab, nurses and Certified Nursing Assistance's entitled Prevention of Decline in Range of Motion and instruction given for evaluation of the skin prior to the application of the device, passive range of motion will be provided prior to the application of the splinting device. Evaluation of the skin will be completed after the removal of the splinting device. 4. The Director of Nursing or designee will conduct random audits 5 times weekly for 4 weeks, then 2 times weekly for 4 weeks, and then 1 time a week for one month. All findings from the conducted audits will be review in QAPI monthly for 3 months. During Quality Assistance the Interdisciplinary Team will make recommendation from the findings obtain by the audits and will make changes to the process as necessary.	

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F 688	Continued From page 6	F 688		

in bed with the head of bed elevated. She was observed to have no splint to her left elbow in place and her left elbow was contracted to the point where her left hand was near her left shoulder.

An observation of Resident #58 was made on 08/31/21 at 10:20 AM. The resident was resting in bed. She was observed to have no splint to her left elbow in place and her left elbow was contracted to the point where her left hand was near her left shoulder.

An observation of Resident #58 was made on 08/31/21 at 11:43 AM. The resident was resting in bed with the head of bed elevated. She was observed to have no splint to her left elbow in place and her left elbow was contracted to the point where her left hand was near her left shoulder.

An observation of Resident #58 was made on 08/31/21 at 2:43 PM. The resident was resting in bed with the head of bed elevated. She was observed to have no splint to her left elbow in place and her left elbow was contracted to the point where her left hand was near her left shoulder.

An interview was conducted on 8/31/21 at 2:45 PM with Nursing Assistant (NA) #4. The nursing stated Resident #58 was part of her assignment and she had not put an elbow splint on the resident ' s left elbow that day.

During an interview conducted with Nurse #2 on 8/31/21 at 2:50 PM she stated Resident #58 was on her assignment, but she wasn ' t very familiar with the resident because she typically worked on

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F 688	Continued From page 7	F 688		

the other side of the facility.

An interview was conducted on 8/31/21 at 2:51 PM with the Unit Manager and the Director of Nursing (DON) revealed the resident did have an order dated 6/25/21 for the resident to have the left elbow splint applied daily, to wear it for 3-4 hours, and to conduct skin checks before and after application.

On 8/31/21 at 3:02 PM an interview was conducted with the Rehabilitation Manager (RM) in conjunction with an observation of Resident #58 ' s room. The RM was able to find the resident ' s other splints for her hands but was unable to find the resident ' s splint for her left elbow. She said she would refer to the therapy records to validate the order for the left elbow splint. The resident was not wearing the splint and was in her room at the time of the observation.

On 8/31/21 at 3:50 PM an interview was conducted with the Rehabilitation Manager (RM) and the Occupational Therapist (OT) in conjunction with an observation of Resident #58 ' s room. The RM was able to find the resident ' s left elbow splint and it had been in the resident ' s wheelchair next to the resident ' s knee brace. An observation of the splint revealed the splint was open to what appeared to be full extension. The OT opened the sides of the splint, loosened clamps on the side which allowed the splint to be flexed at the hinge, to allow it to fit the resident ' s elbow. The OT stated the NAs would have been shown how to adjust the splint by the therapist prior to the splinting program being initiated for the resident. The OT was able to slowly extend the resident ' s left arm to a point where the brace

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F 688	Continued From page 8 was able to fit on the resident ' s left elbow. An interview was conducted 9/1/21 at 2:10 PM with NA #4 and she stated she hadn ' t put the elbow splint on Resident #58 on 8/31/21 and couldn ' t remember putting it on the resident on 8/30/21. The DON was interviewed, in the presence of the Administrator, on 9/1/21 at 4:33 PM. The DON stated splints needed to be applied as directed by the therapy department with education provided by the therapy department for the nursing staff. She said she was working with the therapy department for new guidelines for a splinting program.	F 688		