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

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E 001 SS=D	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The	E 001		2/3/22

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

Electronically Signed | 02/02/2022

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E 001	Continued From page 1 CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and county medic interviews, the facility failed to implement and maintain a comprehensive Emergency Preparedness (EP) Plan. The facility failed to include the exit codes for doors in the EP manual and ensure staff was knowledgeable of exit codes for 1 of 4 employees interviewed (Nurse #2). The findings included: A review completed of the Emergency Medical Services Report for Resident #1 dated for 12/29/21 indicated they were contacted for service due to Resident #1 suffered new onset of altered mental status. A progress note indicated there was a delay entering the facility related to inability of medic's ability to get into building. When medics arrived in Resident #1's room at 1:25am, he was dyspneic (difficulty breathing) and convulsing (shaking). At 1:30am the medic gave Resident #1 a sedative medication via injection to treat his convulsions and he was transferred to the stretcher for transport to the hospital. The progress note revealed medics were unable to locate staff when they were ready to exit the facility. Once staff arrived to let them out, transport continued to be delayed due to facility staff having the wrong code. While waiting for staff to open the door, an intravenous line (line into vein to administer medications) was placed into Resident #1 at 1:34am. The report stated medics left the facility with Resident #1 at	E 001	Resident #1 is no longer a resident at the facility. The facility updated the Emergency Preparedness Manual to include the door codes. The codes were also posted at each nurses station and in the reception area in the front lobby of the center. All staff was in-serviced regarding the exit door codes and location of the codes. Door codes are given to staff members during orientation. Ambulance signage have been posted outside of the facility to direct the ambulance to the appropriate entrance. The Administrator and or Maintenance Supervisor will ask 5 staff member weekly times 4 weeks where the emergency door codes are located. The weekly audits will be analyzed and reviewed at the monthly QA meeting times 3 months	

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E 001	Continued From page 2	E 001		

1:41am.

A review completed of the facility's Emergency Preparedness Binder completed 1/6/22 revealed the Emergency Plan did not include keypad codes for facility exit doors.

A telephone interview was completed on 1/6/22 at 2:50pm with Nurse #2. She indicated emergency medical personnel did not encounter a delay when they entered the facility to provide medical assistance to Resident #1. Nurse #2 stated the medics entered the facility's side entrance (near Resident #1's room). She further stated a facility staff member let the medics in the facility as soon as they arrived. Nurse #2 stated when the medics had Resident #1 ready for transport, she put in the code to the side door to let the medics out and it was the wrong code. Nurse #2 stated she went to find another staff member to get the code for the door. She stated she was unsure of how long she was gone to find the code, but stated it was not long. Nurse #2 revealed she only worked at the facility on a as needed basis and did not remember all the codes.

An Interview was completed on 1/6/22 at 3:00pm with the Director of Nursing and facility Administrator. They stated the front entrance was staffed by an employee 24 hours a day to screen staff and visitors because all facility doors always remained locked. They further indicated all employees were given codes to all doors at employee orientation. The Administrator stated the door codes were not posted anywhere in the facility for staff to access if they did not remember the codes.

A telephone interview was completed on 1/6/22 at

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E 001	Continued From page 3 3:35pm with the front desk receptionist. She indicated she was aware emergency services was at the facility to transfer Resident #1 to the hospital. She stated she was unaware the medics were unable to exit the building and was never asked for the exit code. An interview was completed on 1/6/22 at 4:03pm with Nursing Assistant #4. He indicated he opened the side entrance door for emergency services, but he did not let the medics out when they were ready to leave. He indicated all facility doors were always locked and he was aware of the exit codes to the doors. A written statement received from Medic #1 received on 1/8/22 revealed once medics arrived at the facility, it took them approximately 3 minutes to get to Resident #1. She further wrote Resident #1 was ready to be transported out of the facility at 1:31am, but they were unable to leave due to needing a code to open the door. She stated a staff member attempted to open the door, but had the wrong code, leaving to look for another staff member to help her. Medic #1 indicated it was 1:41am when they had Resident #1 in the ambulance and departing the scene. An interview completed on 1/12/22 at 3:00pm with the Staff Development Coordinator (SDC) revealed all staff were given the codes to all the doors during orientation and were expected to have access to them when they need to open the door.	E 001		
F 000	INITIAL COMMENTS A complaint investigation was conducted on 1/6/22. The survey remained open to obtain	F 000		

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F 000	Continued From page 4 additional interviews. The team returned to the facility on 1/12/22 to obtain additional information. The survey was closed on 1/14/22 when all interviews had been completed. Immediate Jeopardy began on 12/10/22 and was removed on 1/9/22. A partial extended survey was conducted. Substandard Quality of Care was identified at: CFR 483.12(a)(1) at tag F600 at a scope and severity (J) The Statement of Deficiencies was amended on 2/3/22 at tag F842.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff, Nurse Practitioner (NP) and facility and hospital Physician's	F 600	Resident #1 is no longer a resident in the facility.	2/3/22

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F 600	Continued From page 5 interviews, the facility neglected to monitor, assess and identify a resident's skin that was irritated and bleeding behind the ears from a surgical face mask strap that resulted in a partial thickness injury of one ear and a full thickness injury and partial amputation of the other ear for 1 of 2 sampled residents reviewed for injury (Resident #1). Immediate Jeopardy began on 12/10/21 when the NP and staff observed surgical face mask elastic over the resident's ears with debris present, hair stuck, scabbing and redness. This observation was followed by inaccurate assessments, continued use of the same mask, poor hygiene and poor communication about the area. It resulted in skin injury and partial amputation of the ear. Immediate Jeopardy was removed on 1/9/22 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (not actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service training. The findings included: Resident #1 was admitted to the facility on 8/1/18 and had diagnoses of paraplegia, diabetes, chronic pain syndrome and cognitive communication deficit. Review of the physician's orders revealed an order dated 11/1/19 for weekly skin assessments on day shift every Friday.	F 600	Residents who refuse weekly skin assessments have the potential to be affected. The Nursing Supervisor and Unit Coordinator interviewed direct care staff on 1/7/22 and 1/8/22 to determine if any other residents have refused to change their face mask or refused to have skin assessed, no other residents were identified. The Staff Development Coordinator and/or Director of Nursing in-serviced the licensed nurses regarding the process for completing and documenting weekly skin assessments. Education included notification of the Physician and/or Nurse Practitioner and responsible party for resident refusals of weekly skin assessments. The SDC and/or DON in-serviced the Certified Nursing Assistants(CNA)and agency staff regarding the use of surgical masks and replacement of masks when soiled, notification to nurse of resident refusals of care including removal of surgical masks and notification to nurse for alterations in the resident's skin integrity. The above in-service will be included in the new employee orientation program for direct care staff. The Director of Nurses and the SDC will observe two Nurses performing weekly skin assessments to validate the accuracy of the assessment and the documentation of the findings. Audits will occur 2x weekly for 4 weeks, weekly x4, then	

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F 600	Continued From page 6 The Care Area Assessment for behavioral symptoms for the Annual Minimum Data Set (MDS) Assessment dated 4/14/21 noted the resident was resistant to care and combative with staff. This was related to poor judgement, impaired thinking and memory problems. The resident's confusion often leads to his refusals of care. His behaviors are deliberate in that he is refusing to comply. He hits and kicks at staff when they are providing care. The care plan considerations were to avoid complications and to minimize risks. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 10/9/21 revealed the resident had severe cognitive impairment and had no behaviors. The MDS noted the resident required limited assistance with activities of daily living (ADLs) with the exception that he required total assistance with bathing. The MDS noted the resident was not steady during transitions and only able to stabilize with staff assistance, had no impairment in range of motion of the upper extremities and used a wheelchair for mobility. The care plan for Resident #1 last reviewed on 11/23/21 revealed the resident had the potential to demonstrate verbally abusive and physical behaviors due to poor impulse control. The intervention was to monitor the resident for behaviors. The care plan noted the resident was resistive to care related to dementia and refused baths, showers and vital signs. The intervention was if the resident resisted ADL care, reassure the resident and leave and return 5-10 minutes later and try again. Review of the progress notes for Resident #1 from 10/1/2021 to 12/29/21 revealed no documentation the resident had refused to	F 600	monthly x3 until compliance is sustained. The Director of Nursing will report findings of skin assessment observation audits to the Quality Assurance/Performance Committee x3 months or until a pattern of compliance maintained. The Director of Nurses is responsible for overall compliance.	

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remove the face mask or any concerns with skin issues behind the ears related to the face mask. There was no documentation the resident refused weekly skin assessments.

NA #2 stated in an interview on 1/6/22 at 11:59 AM that approximately one month ago she reported several times to the nurse that the back of the resident's ears was bleeding, and the mask strap was stuck, and Nurse #1 came to the room to look at the resident's ears and his hair was stuck to the strap and the NP came to the shower room to look at his ears and his hair was stuck to the strap and the NP cut off the mask. The NA further stated there were scabs and dried blood. The NA stated she washed behind the resident's ears but was unable to remove all the dried blood because it was painful to the resident and he was combative. The NA stated the NP did not give her any instructions regarding the face mask. The NA stated since that time the area was scabbed over, but she did not see any active bleeding. The NA stated the resident continued to wear the same type of face mask.

On 1/6/22 at 11:05 AM, NA #1 stated in an interview the resident was often combative with care and if she spoke calmly to the resident and explained what she needed to do and why, sometimes he would allow her to shower or bathe him and other times he would refuse. The NA stated approximately 2 weeks ago she had to cut off the face mask and the top of his ears were painful with irritation and bleeding from the ear and his hair was tangled up and she had to cut it off. The NA stated she told Nurse #1 about the problem and she went in the room to look at his ears. The NA stated the resident would wear the mask all the time even when he went to sleep,

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and she and the Nurse told him to take off the mask when he went to bed or was in his room.

Weekly Skin Assessment forms dated 12/03/21 and 12/10/21 and signed by Nurse #1 read: "Skin intact. No wounds."
The Nurse Practitioner saw Resident #1 on 12/10/21 at the request of Nurse #1 and NA #2. He was in the shower and the staff had concerns about his ears. The NP did not document a note after the 12/10/21 observation. The NP documented a note about the 12/10/21 observation on 12/17/21. The note indicated "the patient was initially noncompliant and resistant to examination. Patient denies any ear complaints or needs. With the assistance of the NA noted above each ear the patient with long hair sticking above the ear with the mask ties hold over the ears with debris present. Initially with concern of scab, but upon cutting the resident's hair sticking to the area and removing the debris, noted mild skin redness, skin intact, no open wound. Recommended skin care and the use of a different mask that had ties that loop around the head instead of above the ears. Discussed with the CNA and patient's nurse."

There was not a nurse's note documented on 12/10/21 regarding the observations made in the shower.

Review of a physician's note dated 12/14/21 revealed the resident was seen by the physician but there were no notes regarding an issue with the resident's ears or the face mask.

The 12/17/21 NP note continued with "On reassessment, patient with recurrent debris over the ears, no open wound, minimal redness, no

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drainage. The resident refused to allow touch to the ears, refused examination. With ongoing noncompliance with personal care or hygiene. Discussed with staff, recommended as before to provide skin care, wash the area, avoid a mask that had ties that loop over the ears."

On 1/6/21 at 11:00 AM, an interview was conducted with the Nurse Practitioner (NP) that worked with the resident. The NP stated that weeks before the resident went to the hospital, he saw the resident while in the shower and upon assessment the resident had dirt in his hair above the ears and the hair was cut and the dirt came off with the hair. The NP further stated there was some mild redness and the skin was intact. The NP stated he told NA #2 and Nurse #1 to change the mask to one where the straps went around the head instead and to provide good skin care behind the ears. The NP stated he did not write orders for this.

On 1/14/22 at 8:40 AM the Nurse Practitioner stated in an interview that he was asked to go in and look at a resident in the shower (12/10/21) and saw a hygiene issue and not a medical issue, so he did not document his observations.

A Weekly Skin Assessment form dated 12/17/21 and signed by Nurse #1 read: "Skin intact. No wounds."

On 1/7/21 at 10:30 AM an interview was conducted with Nurse #1 regarding the skin assessments she signed for 12/03/21, 12/10/21 and 12/17/21 where she documented the skin was intact and there were no wounds. The Nurse initially stated the resident would not allow her to do the skin assessments. The nurse was asked if

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she ever documented the resident refused the assessments and the Nurse stated: "No." The Nurse further stated the NAs would let her know if the resident had any skin issues. The Nurse later retracted her statement (1/7/22 at 10:45 AM) and stated she did not remember whether she was able to do the skin assessments for 12/03/21, 12/10/21 or 12/17/21 or not.
A Weekly Skin Assessment dated 12/24/21 and signed by Nurse #1 read: "Skin intact. No wounds."

An interview was conducted with Nurse #1 on 1/6/22 at 10:37 AM. The Nurse stated Resident #1 was frail, uncooperative and would curse at the staff. The Nurse further stated the resident did not like to bathe or shower, wash behind his ears or wash his hair and would kick at the staff. The Nurse stated if the face mask was not on his face it was pulled down below his chin. The Nurse stated the resident was able to remove the face mask himself.

On 1/6/22 at 12:15 PM Nurse #1 stated in an interview that she did not recall the NP giving her any instructions regarding putting a different kind of face mask on the resident or any specific instructions regarding skin care. The Nurse further stated the mask the resident was wearing was the only kind of mask they had in the facility. The Nurse stated even if the NP had given any orders for skin care the resident would not have allowed it to be done. The Nurse was asked about the skin assessment she signed on 12/24/21 that stated "Skin intact. No wounds" and the Nurse stated the resident would not remove his clothing and would not let her look at his ears.

On 1/6/22 at 11:19 AM Nurse #1 stated in an

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interview that the resident did not want to take off the mask because if was painful and he would fight the staff. The Nurse further stated his ears were red with brown material behind his ears. The Nurse stated the NP was aware and the NP cleaned his ears when in the shower about one month ago. The Nurse stated she had not heard anything about his ears since that time.

The Director of Nursing (DON) stated in an interview on 1/6/22 at 12:45 PM that the resident was noncompliant with taking off the mask. The DON further stated on one occasion she noticed the mask was visibly soiled, but he refused to take it off and put on a clean one.

On 1/6/21 at 12:52 PM the Administrator stated she was not aware the resident had any skin breakdown from the mask. The Administrator further stated on one occasion (unable to recall the date) she could see the mask was visibly soiled and he would refuse to take it off and the resident was observed to jerk and pull on the mask. The Administrator stated she told the Unit Coordinator to take a look at it.

On 1/6/21 at 12:58 PM an interview was conducted with the Unit Coordinator who stated she was not aware of any skin breakdown or bleeding behind the resident's ears. The Unit Coordinator stated one day (maybe the day before he went out to the hospital but not sure) she was discussing the face mask with the NP and asked him about getting a scarf for the resident to wear instead of the surgical mask and the NP told her that would be fine. The Unit Coordinator stated she purchased the scarf the same day and when she gave it to the resident, he threw it on the floor and would not wear it. The

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Unit Coordinator further stated the resident liked to wear a hat and they asked him about sewing 2 buttons on the hat to loop the ear straps to and the resident refused to let them do this. The Unit Coordinator stated on one occasion (could not recall the date) the wound doctor was in the building and she asked him to look at the resident's ears and the resident refused and would not allow him to examine his ears. The Unit Coordinator stated the resident was only required to wear the face mask when he was out of his room but at some point, he had become attached to the mask and did not want to take it off.

On 1/6/21 at 4:50 PM an interview was conducted with the DON and the Administrator who stated the resident was his own Responsible Party and a family member was his emergency contact, and they would call her in an emergency.

On 1/6/21 at 5:25 PM an interview was conducted with the Nurse Practitioner (NP) who stated he had multiple discussions with the family member listed as the resident's emergency contact regarding his refusal of personal care and the health issues it could cause. The NP further stated he talked with her about the resident's aggressive behaviors toward staff and the NP stated the family member told him she had tried to talk to him before regarding his behaviors but was not successful. The NP was unable to provide documentation of these conversations.

An interview was conducted with the Nurse Practitioner, the Unit Coordinator and NA #2 on 1/12/22 at 11:30 AM. The Unit Coordinator stated on the same day the Nurse Practitioner recommended a different type of mask she offered the resident a mask that tied in the back

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of the head, but he refused. NA #2 stated on the day the Nurse Practitioner recommended a different mask, she also offered him the mask that tied in the back of the head and he refused the mask. The NA further stated the next day she offered the resident a mask that tied behind the head and he refused.

On 1/10/22 at 3:58 PM the Director of Nursing (DON) stated in an interview that if a resident refused a skin assessment, the nurse should wait 5-10 minutes and try again. The DON further stated if the resident still refused, the nurse should document the refusal, notify the DON, the physician and the resident's contact about the refusal.

On 1/10/22 at 4:55 PM an interview was conducted with the physician who cared for Resident #1 in the facility. The Physician stated the resident was very difficult, frequently refused care and his hygiene was not the greatest. The Physician further stated even when he tried to auscultate his chest the resident would swing at him. The Physician stated he did not have the resident's notes to review with him but unless the resident complained of something or the staff told him about an issue, he would probably not know about it. The Physician stated that skin issues can develop from wearing a face mask in 2-3 days.

On 12/29/21 at 6:06 AM a progress note written by Nurse #2 revealed Resident #1 had an altered mental status, a fever and was sent to the hospital for further evaluation.

On 1/6/21 at 3:00 PM an interview was conducted with NA #3 who was working on the 11 PM to 7

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AM night shift on 12/28-29/21. The NA stated he heard a commotion and went in the resident's room between 12-1:00 AM and the resident was jerking and struggling to breathe, and EMS (Emergency Medical Services) was called. The NA stated EMS told him the resident's mask was caught on his ear. The NA further stated he had not seen any problems with the resident's ear and no blood on his pillow.

On 1/6/22 at 2:55 PM an interview was conducted with Nurse #2 who was working when Resident #1 sent out to the hospital on 12/29/21. The Nurse stated the NA told her the resident was not acting like himself and was breathing different and she assessed him and his vital signs were off (could not remember how they were off) and EMS was called. The nurse was not able to provide any information regarding a problem with the resident's ears.

An attempt was made to interview the EMS staff that responded to the facility on 12/29/21. EMS provided a written statement on 1/10/22 at 8:49 AM that revealed on their arrival to the room of Resident #1, the mask ear loop had lacerated his left ear almost middle way. The right loop of the mask had begun to grow into the ear and had a scab on top of it.

On 12/29/21 the Emergency Department Physician documented that the physical exam was remarkable for a mask strap eroding into the left ear with approximately half of the ear displaced from his head. This does not appear to be an acute change given minor bleeding as well as some granulation tissue that has already begun to form. The face mask was removed, and a full thickness wound noted to the left ear with

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cartilage visible.

A skin assessment, signed by a hospital Registered Nurse, dated 12/29/21 noted the following: Right outer ear, partial thickness wound. Left outer ear, full thickness pressure injury with visible cartilage. Left outer ear partially amputated.

On 1/11/22 at 10:00 AM an interview was conducted with a physician that attended to Resident #1 in the hospital. The Physician stated the resident had a pressure injury between both ears and the skull from the ear loop mask that was "1/2 inch to 1 inch deep. The Physician stated it would take days to weeks for the ear loop mask to cause this type of injury. The Physician further stated at this point the only treatment would be to leave off the mask and provide wound care. At this time of this interview, Resident #1 remained in the hospital.
The administrator was identified of the immediate jeopardy on 1/7/22 at 12:20 PM.

The facility provided a credible allegation of Immediate Jeopardy Removal that indicated:

Credible Allegation of Immediate Jeopardy Removal:

The facility alleges Immediate Jeopardy removal on 1/9/22.

The facility failed to monitor, assess and identify skin that was irritated behind the ears from a surgical face mask that resulted in a partial thickness injury of one ear and full thickness injury of the other ear for Resident #1.

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Resident #1 exhibits behaviors of refusing care and assessment by facility staff. Resident #1 refused to remove surgical mask and refused personal care. Resident #1 developed opened areas to bilateral ears related to extended wear of surgical mask and refusal of care.
Nurse #1 documented in the residents' medical record that a weekly skin check was completed on 12/3/21, 12/10/21, 12/17/21, skin was noted to be intact on all assessments.

The Nurse Practitioner stated in his note on 12/17/21 that this was a follow-up visit " from initial visit on 12/10/21 when patient was seen with patients nurse and CNA at staff request while patient was in shower room ".

Resident #1 was showered on 12/10/21 by NA #2. She reported to Nurse #1 and NP (during shower) that she thought Resident #1 had scabs and dried blood behind his ears. The Nurse Practitioner assessed Resident #1 ears in the shower with Nurse #1 and Nursing Assistant #2 present. Resident #1 was initially non-compliant and resistant to examination, with assistance from Nursing Assistant #2 Nurse Practitioner was able to assess the resident's ears he noted that Resident #1 had long hair sticking above the ear with the mask ties hold over the ears with debris present. The NP states initial concern was for a scab, but upon cutting Resident #1 hair sticking to the area and removing the debris Resident #1 had mild skin redness, skin intact, no open wound. The NP recommended to provide skin care, wash area, avoid mask that has ties that loop over the ears.

The Unit Coordinator stated that she provided alternative scarf mask for resident #1 that would

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not cause pressure behind the ears she was (unable to recall the date). Resident #1 refused the alternative scarf mask and threw it on the floor when facility staff attempted to implement its use. Resident preference was to wear a standard surgical mask with ear straps.

His preference was to wear a standard surgical mask with ear straps.

Resident was seen by the Physician on 12/14/21 he did not note any skin concerns.

Nurse #1 failed to accurately document Resident #1's refusals of weekly skin assessment on 12/24/21. Nurse #1 failed to notify the physician, NP, and emergency contact of resident refusal of weekly skin assessments on 12/24/21.

The Nurse Practitioner stated on 1/6/22 that he had spoken with Resident #1 emergency contact on multiple occasions regarding his refusal of care, aggressive behaviors and health issues that could arise from refusal of care and behaviors (the facility is unable to determine the exact date). The Nurse Practitioner further stated that Resident #1's emergency contact stated that she had attempted to speak with Resident #1 related to his behaviors and refusal of care however it did not have an impact on Resident #1 and there was no change in his behaviors (the discussion was not documented into the medical record).

On 12/29/21 at 6:06 AM Resident #1 was not responding to verbal commands, he had an elevated temperature and respirations. Resident #1 was sent to the hospital for further evaluation. Upon assessment in the emergency department it was noted that Resident #1 had wounds to

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bilateral ears.

Residents who refuse weekly skin assessment have the potential to be affected. The Nursing Supervisor and Unit Coordinator interviewed direct care staff on 1/7/22 and 1/8/22 to determine if any other residents have refused to change their face mask or refused to have skin assessed, no other residents were identified. The license nurses have been instructed to notify Physician, Nurse Practitioner, and Responsible Party of refusal of weekly skin check, documentation of refusal will be reflected in the resident's medical record.

The Staff Development Coordinator and/or Director of Nursing began in servicing on 1/7/2022 of all licensed nurses regarding the process for completing and documenting weekly skin assessments. Education to include notification of the Physician and/or Nurse Practitioner and responsible party for resident refusals of weekly skin assessments. The Staff Development Coordinator and/or Director of Nursing will validate competency of licensed nurses by return demonstration of licensed nurse performance of head to toe skin assessment and documentation of assessment. In-service education and competency validation will be completed prior to next scheduled shift.

On 1/7/22 in-service education by the Staff Development Coordinator and/or Director of Nursing began for certified nursing assistants and agency staff. Education to include the use of surgical masks and replacement of masks when soiled, notification to nurse of resident refusals of care including removal of surgical masks and notification to nurse for alterations in the

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resident's skin integrity. In-service education will be completed prior to next scheduled shift.

On 1/7/22 in-service education by Staff Development Coordinator and/or Director of Nursing began for all staff including agency staff, to include the use of surgical masks and replacement of masks when soiled. The direct care staff was instructed to report to the nurse any concerns related to mask use to include alterations in skin integrity and refusals by resident to wear mask appropriately. In-service education will be completed prior to next scheduled shift.

On 1/7/22 the Director of Nursing and Facility Administrator reviewed with Nurse Practitioner the expectation of initiation of orders for all required changes in resident's plan of care.

The IDT team including the Medical Director met on 1/7/22 and formulated the credible allegation and removal plan for immediate jeopardy.

The Director of Nurses and Administrator is responsible for overall compliance.

The facility's credible allegation of Immediate Jeopardy was validated on 1/12/22 from 1:00 PM to 2:00 PM where multiple interviews were conducted with the nursing assistants working in the facility were aware if they observed any new skin problems to report them to the nurse and/or the Unit Coordinator, the Director of Nursing or the Administrator. Interviews with the nurses revealed all changes in skin condition were to be documented on a skin assessment form, the provider, Unit Coordinator and the family contact was to be notified. The Nurses were also aware if

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F 600	Continued From page 20 a resident refused a skin assessment to document this in the medical record and report to the medical provider, the Director of Nursing and the family contact. In-service information and staff sign in sheets were reviewed and found to be complete. Return demonstration of skin assessments were reviewed with no concerns. The facility's Credible Allegation of Immediate Jeopardy removal was validated, and Immediate Jeopardy was removed on 1/9/22.	F 600		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review staff and Nurse Practitioner interview the Nurse Practitioner failed to document an examination for 1 of 2 residents whose documentation was reviewed (Resident	F 711	Resident #1 is no longer resides at the facility. All Residents have the potential to be	2/3/22

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F 711	Continued From page 21 #1). The findings included: On 1/6/22 at 11:59 AM, Nursing Assistant (NA) #2 stated in an interview that approximately one month ago she was giving Resident #1 a shower and the resident's hair was stuck in the mask and she observed a scab and dried blood behind the resident's ears. The NA stated the Nurse Practitioner (NP) was asked to look at the resident's ears. The NA further stated the NP cut off the resident's face mask to examine the resident's ears. The Nurse Practitioner (NP) stated in an interview on 1/6/22 that weeks before the resident went out to the hospital, he saw the resident while in the shower. The NP further stated the resident had dirt in his hair above the ears and he cut the hair and the dirt came off with the hair. The NP stated there was some mild redness and the skin was intact. The NP stated he told NA #2 and Nurse #1 to change the mask from the kind where the straps went around the ears to one that the straps went behind the head and to give good skin care behind his ears. The NP stated he did not write orders for this. The Director of Nursing stated in an interview on 1/13/21 at 10:30 AM it had been determined the NP saw the resident in the shower on 12/10/21. Review of the medical record revealed no documentation of the NP's examination or observations on 12/10/21. There was a physician's note dated 12/14/21 that revealed the resident was seen by the physician	F 711	affected. The Nurse Practitioner was inserviced by the Regional Nurse on 1/24/22 regarding the importance of documenting examinations when they occur. The Nurse Practitioner will provide the Director of Nursing with a list of residents he examined on a weekly basis to ensure documentation was completed. New Nurse Practitioner's to the facility will be inserviced during orientation regarding the importance of documenting examinations when they occur. Nursing Administration will audit the Nurse Practitioner's visits for documentation weekly x4 weeks then monthly x3 months. Audit results will be reviewed and analyize during monthly QAPI meetings times three months with a subsequent plan of correction as needed. The DON is responsible for overall compliance.	

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but there were no notes regarding an issue with the resident's ears or the face mask.

There was a NP note dated 12/17/21 that the resident was seen today for follow-up and noted resident was recently seen (12/10/21) with the resident's nurse and NA at the staff request while the resident was in the shower with concerns about the patient's ears. With the assistance of the NA, noted above each ear the resident had long hair sticking above the ear with the mask ties hold over the ears with debris present. There was initially a concern about a scab but upon cutting the resident's hair and removing the debris, noted mild skin redness and the skin was intact with no open wound. Recommended skin care and the use of a different mask that has ties that loop around the head instead of above the ears. Discussed with NA and Nurse. On reassessment, the resident had recurrent debris over the ears, no open wound and minimal redness with no drainage. The resident refused to allow touch to the ears and refused examination. With ongoing noncompliance with personal care or hygiene, recommended as before to provide skin care, wash the area and avoid mask that has ties that loop over the ears.

On 1/10/22 at 4:55 PM an interview was conducted with the Physician that cared for Resident #1 in the facility. The Physician stated the resident was very difficult, frequently refused care and his hygiene was not the greatest. The Physician further stated he did not have the resident's notes to review with him but unless the resident complained of something or the staff told him about an issue, he would probably not know about it. The Physician stated that skin issues can develop from wearing a face mask in 2-3

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F 711	Continued From page 23 days. On 1/14/22 at 8:40 AM the Nurse Practitioner stated in an interview that he was asked to go in and look at a resident in the shower and saw a hygiene issue and not a medical issue, so he did not document his observations. On 1/14/22 at 11:27 AM the Director of Nursing stated in an interview she would expect the NP to let her know if he observed anything of concern during an examination and would expect him to document the findings.	F 711		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services 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)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding	F 726		2/3/22

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F 726	Continued From page 24 to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and county medic interviews the facility failed to demonstrate staff competency regarding knowledge of exit code for facility doors for 1 of 4 staff members (Nurse #2) reviewed. The Findings included: A review completed on 1/6/22 of the Emergency Medical Services Report for Resident #1 dated for 12/29/21 revealed a progress noted that indicated there was a delay entering the facility related to inability to get into building. The note further revealed once Medics were ready to transport Resident #1 out of the facility, no facility staff were to be found, and the door could not be opened without the code. A telephone interview was completed on 1/6/22 at 2:50pm with Nurse #2. She stated emergency medical personnel did not encounter a delay when they entered the facility. Nurse #2 further indicated the medics entered the facility's side entrance (near Resident #1's room). She stated another facility staff member opened the door for the medics as soon as they arrived. Nurse #2 went on to state, once the medics had Resident #1 ready for transport, she put the code in to the side door and realized at that time she did not	F 726	Nurse #2 has been inserviced on the door codes and the location of the codes. All residents have the risk to be affected. The Staff Development Coordinator, Maintenance Director, and Director of Nursing inserviced the facility staff regarding the exit door codes and location of the list of codes. The Nurses have been inserviced to notify the Receptionist to allow EMS to enter and exit the center. In the absence of a Receptionist the Nurse will appoint another person to access the door codes to allow entrance and exiting of the EMS into the center. Ambulance entrance signs have been posted around the center directing them to the correct entrance. This in-service will be included in the new employee orientation. The Administrator and or Maintenance Supervisor will ask 5 staff members weekly times 4 weeks where the emergency door codes are located. The audits will be reviewed during the centers monthly QAPI meeting for 3	

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	345070	A. BUILDING _____ B. WING _____	C 01/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

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F 726	Continued From page 25 know the code. Nurse #2 indicated she went to find another staff member to get the code for the door. She stated she was unsure of how long she was gone to find the code but stated it did not take long. Nurse #2 revealed she only worked at the facility on an as needed basis and did not remember all the codes. An Interview was completed on 1/6/22 at 3:00pm with the Director of Nursing and facility Administrator. They indicated all employees were given codes to all doors at employee orientation. The Administrator stated the door codes were not posted anywhere in the facility for staff to access if they did not remember the codes. A written statement received from Medic #1 received on 1/8/22 revealed once medics arrived at the facility, it took them approximately 3 minutes to get to Resident #1. She further wrote Resident #1 was ready to be transported out of the facility at 1:31am, but they were unable to leave due to needing a code to open the door. She stated a staff member attempted to open the door, but had the wrong code, leaving to look for another staff member to help her. Medic #1 indicated it was 1:41am when they had Resident #1 in the ambulance and departing the scene. An interview completed on 1/12/22 at 3:00pm with the Staff Development Coordinator (SDC) revealed all staff were given the codes to all the doors during orientation and COVID Reeducation In-services and were expected to have access to them when they need to open the door.	F 726	months.	
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		2/3/22

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F 842	Continued From page 26	F 842		

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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F 842	Continued From page 27 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Nurse Practitioner interview, the facility failed to maintain complete and accurate clinical records for 1 of 2 residents whose medical records were reviewed (Resident #1). The findings included: 1a. Review of the facility ' s progress notes for October 1, 21 to December 29, 21 revealed no documentation of a problem with the resident ' s surgical face mask or skin issues related to the	F 842	Resident #1 no longer resides in the center. All residents who wear face mask are at risk. A one time skin audit of residents ears was performed by the Licensed Nurses to identify skin integrity issues related to wearing surgical mask. No other residents were identified. The Licensed Nurses was inserviced by the Staff Development Coordinator and	

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F 842	Continued From page 28 face mask. There was no documentation that other face masks had been provided for the resident as recommended by the Nurse Practitioner related to a problem with the face mask that looped around the resident ' s ears. 1b. On 1/6/22 at 11:00 AM an interview was conducted with the Nurse Practitioner (NP) that cared for Resident #1 in the facility. The NP stated that weeks before the resident went to the hospital, he saw the resident while he was in the shower and he had dirt in his hair above the ears and he cut the hair and the dirt came off with the hair. The NP further stated there was some mild redness and the skin was intact. The NP stated he told Nursing Assistant #2 and Nurse #1 to change the mask from the kind where the straps went around the ears to the one that went behind his head and to give good skin care behind his ears. The NP stated he did not write specific orders for this. On 1/12/22 at 10:46 AM The Director of Nursing stated in an interview that when new skin issues were identified they should be documented on a skin assessment form and in the progress notes and to not do so was unacceptable. 1c. Review of the record revealed a Weekly Wound/Skin Assessment completed and signed by Nurse #1 on 12/3/21, 12/10/21, 12/17/21 and 12/24/21. The 4 skin assessments read: "No wounds. Skin intact." An interview was conducted with Nurse #1 on 1/6/22 at 12:15 PM. The Nurse was asked about the skin assessment dated 12/24/21 that read: "Skin intact. No wounds," and if she completed the skin assessment. Nurse #1 stated the	F 842	Director of Nursing regarding the importance of documenting skin integrity issues related to wearing face mask in the medical records. The direct care staff received training regarding the different types of surgical mask available to the residents. The Nursing Assistants were in-serviced on the importance of accurate documentation with the emphasis on walking. The Director of Nursing or Staff Development Coordinator will observe 2 Nurses performing a skin audit 2x weekly x4 weeks, then weekly x4 and monthly x3 to ensure accuracy in documenting skin integrity. The MDS Coordinator will audit 5 resident ADL records for accurate documentation in the ability to walk 2 times weekly for 4 weeks then weekly times 4 weeks then monthly time 3 until compliance is sustained. The above training will be included in the new employee orientation. Data results of the audit will be reviewed and analyzed in the centers QA meeting monthly x3 months with a plan of correction as needed. The Director of Nurses is responsible for overall compliance.	

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resident refused to allow her to do the skin assessment.

A separate interview was conducted with Nurse #1 on 1/7/22 at 10:30 AM regarding the skin assessments she completed on 12/3/21, 12/10/21 and 12/17/22. The Nurse initially stated the resident would not allow her to do the skin assessments. The Nurse was asked if she ever documented the resident refused the skin assessments and the Nurse stated: "No." The Nurse stated the Nursing Assistants would let her know if they observed any skin problems for the resident. On 1/7/22 at 10:45 AM the Nurse stated she could not specifically remember the events on the dates of the assessments or if the resident refused the assessments or not.

On 1/10/22 at 3:58 PM the DON stated in an interview that if a resident refused a skin assessment the nurse should leave and try again in 5-10 minutes and if the resident still refused, document the refusal and notify the DON, the physician and the resident ' s contact of the refusal.

1d. A review of Resident #1's Resident Task Report for October 2021 revealed staff had documented Resident walked in the hallway on 10/3/21, 10/4/21, 10/5/21, 10/7/21, and 10/8/21.

An interview conducted with Nursing Assistant (NA) #1 on 1/6/22 at 4:35pm. She confirmed the Resident had some movement in his legs but was unable to walk. She further stated she had never witnessed the Resident walking. She further stated she incorrectly documented in the Resident Task Report he was walking in the hallway when he did not on 10/4/21.

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F 842	Continued From page 30 An interview was completed with the MDS Nurse on 1/6/22 at 5:05pm. She stated she reviewed the Task Report for Residents for any incorrect documentation prior to submitting the MDS and when incorrect documentation was found, she did one on one education with the NA and had them correct the task. The MDS Nurse indicated NA #1 and NA #4 had documented in the Task Report for Resident #1 he walked in the hallway on 10/3/21, 10/4/21, 10/5/21, 10/7/21, and 10/8/21 and she had not had staff correct the documentation prior to completing the MDS. She further indicated the Resident had a diagnosis of paraplegia and had movement in his legs, but it was impaired. An interview conducted with NA #4 on 1/6/22 at 5:15pm revealed he was familiar with Resident #1. He stated the Resident was able to move his legs some to assist with transferring surfaces, but he was unable to walk. He further stated he had not witnessed the Resident walking, stating the Resident used an electric wheelchair for movement around the facility. NA #4 indicated he incorrectly documented in the Resident Task Report the Resident was walking in the hallway, when he was not on 10/3/21, 10/4/21, 10/5/21, 10/7/21, and 10/8/21. A telephone interview was conducted with the Director of Nursing on 1/7/22 at 2:52pm. She indicated it was her expectation the MDS Nurse check all documentation the Resident Task Report for accuracy. She further stated when inaccuracies were found, corrections should have been made and education provided to staff.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		2/3/22

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F 880	Continued From page 31 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 32 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, the Center for Disease Control (CDC) guidelines for the use of Personal Protective Equipment (PPE), CDC COVID-19 Data Tracker for Durham County Transmission Rate, and staff interviews, the facility failed to wear eye protection when caring for residents for 2 of 2 nursing units (Station 1 and Station 2). The findings included: The facility policy titled CDC COVID-19 Strategies	F 880	The Staff Development Coordinator and the Director of Nursing immediately inserviced the staff to the CDC guidelines related to wearing face shields or goggles when caring for residents. Staff identified as not wearing eye protection was given a face-shield or goggles. All residents have the potential to be affected by staff not wearing eye protection when providing care. The Staff	

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F 880	Continued From page 33 for Optimal Supply of Eye Protection dated 9/13/21 read: "In areas of substantial to high transmission in which healthcare personnel are using eye protection for all patient encounters extended use of eye protection may be considered as a conventional capacity strategy." "Conventional capacity: Measures consisting of engineering, administrative and personal protective equipment controls that should already be implemented in general infection prevention and control plans in healthcare settings." The CDC COVID-19 Data Tracker for Durham County on 1/6/22 noted the county transmission rate was extremely high with a transmission rate of 23.8 percent positive cases. During the initial tour of the facility on 1/6/22 at 9:50 AM, NA #5 was observed on Station 2 in a resident's room and was assisting a resident to put on his socks and shoes. The NA was not wearing eye protection. During the observation, NA #5 stated the facility did educate her on the COVID policy and wearing eye protection while doing resident care. The NA stated she did not like to wear the eye protection because it got in the way when working with residents. During the initial tour of the facility on 1/6/22 at 10:00 AM 2 Nursing Assistants (NAs) were observed to go in and out of resident rooms on Station 1 wearing a face mask but no eye protection. A nurse was observed to enter a resident's room on Station 1 with a face mask but no eye protection. Another nurse was observed in the hallway at the medication cart on Station 1 with a resident beside her in a wheelchair waiting for medications. The Nurse was wearing a face mask but no eye protection. There was a NA on	F 880	Development Coordinator and Director of Nursing inserviced all staff to the CDC recommendation to wear eye protection face-shields/goggles when providing care related to the county transmission rate being substantial to high. The above in-service will be included in the orientation for new hires. The Director of Nursing/Staff Development Coordinator will monitor through direct observation 10 staff members wearing eye protection(face shields or googles) when providing care. These audits will occur 3x weekly for 4 weeks. Then 2x weekly for 4 weeks then monthly x3. Audit results will be reported by the Staff Development Coordinator in the monthly QAPI meeting x3 months with a plan of correction as needed. The Director of Nursing is responsible for overall compliance.	

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F 880	Continued From page 34 Station 2 that was wearing a face mask but no eye protection. There were 2 staff members observed on Station 2 that were wearing eye protection. On 1/6/22 at 5:55 PM The Staff Development Coordinator/Infection Control Nurse stated in an interview the transmission rate had been high for the past several weeks and they had an outbreak last week with 4 employees that tested positive for COVID. The Infection control nurse stated the staff should have been wearing eye protection. On 1/6/22 at 5:35 PM the Director of Nursing stated she did not realize the COVID transmission rate was so high. The DON was unable to say how long the staff had not been wearing eye protection.	F 880		