STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	C 01/14/2022

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NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted on 1/14/22. 3 of the 5 complaint allegations were substantiated resulting in deficiencies. Event ID# VHTC11.	F 000		
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 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 record review, observations and staff	F 657	Northampton Nursing and Rehabilitation	2/15/22

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

Electronically Signed | 02/11/2022

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F 657	Continued From page 1 interviews, the facility failed to update the care plans for 2 of 4 residents reviewed for care plans. (Resident #1, #2) Findings included: 1. Resident #1 was admitted to the facility on 9/21/2021, and diagnoses included peripheral vascular disease and ulcerations to the left lower extremity. The care plan dated 9/22/2021 indicated Resident #1 had actual venous stasis ulcerations to both lower legs. Interventions included to evaluate and assess ulcer weekly and document results, observe for signs and symptoms of pain and infection and notify the physician and to provide treatment as ordered by physician. A goal for venous ulcerations to show positive signs of healing was dated initiated on 12/23/21 and was revised on 1/2/2022. There were no new interventions listed for the care plan for venous stasis ulcerations. The admission Minimum Data Set (MDS) assessment dated 9/27/2021 indicated Resident #1 was moderately cognitively impaired and the presence of vascular ulcerations. Physician orders dated 11/17/2021 revealed Resident #1 was ordered the application of lymphedema sleeves to both legs twice a day for one hour to decrease edema. Resident #1's wound care clinic notes recommendations included the use of lymphedema sleeves to reduce edema in his lower legs.	F 657	Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Northampton Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Northampton Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F657 Care Plan Timing and Revision On 2/8/22, the Facility Consultant updated the care plan for resident #1 to reflect accurately the type and location of venous stasis ulcers and skin interventions to include use of lymphedema sleeves. On 2/8/22, the Facility Consultant reviewed care plan for resident #2 for interventions related to treatment of UTI to include use of IV antibiotic therapy. Resident #2 no longer receives IV antibiotic therapy.	

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F 657	Continued From page 2 Nursing documentation in November 2021 and December 2021 revealed lymphedema sleeves were not available. Nursing documentation revealed lymphedema sleeves were applied to Resident #1 lower legs on 1/11/2022. On 1/14/2022 at 2:35 p.m., Resident #1 was observed lying in bed with lymphedema sleeves applied to both lower extremities. On 1/14/2022 at 5:29 p.m. in an interview with the MDS Nurse, she stated she updated care plans with quarterly and annual assessments. She stated the nursing staff updated care plans between the quarterly and annual assessments based on new orders, and the lymphedema sleeves arrived at the facility for Resident #1 this week. On 1/14/2022 at 5:30 p.m. in an interview with Nurse #2, she stated the use of the lymphedema sleeves were not listed on Resident #1's care plan as an intervention for venous ulcers. She stated Resident #1's care plan should have been updated when the order was written for the lymphedema sleeves. She stated she activated the order for the lymphedema sleeves and missed updating Resident #1's care plan. On 1/14/2022 at 5:32 p.m. in an interview with the Director of Nursing, she stated all nurses had access to update the care plans and Resident #1's care plan should had been updated when the lymphedema sleeves were ordered. 2. Resident #2 was admitted 12/20/2020 to the facility. Her diagnoses included dementia and urinary tract infection.	F 657	On 2/8/22, the Facility Consultant completed an audit of the care plan for all residents currently receiving IV therapy and/or IV antibiotics. This audit is to ensure the resident is care planned appropriate for use of IV therapy and/or IV antibiotics. There were no residents currently receiving IV therapy or IV antibiotics. On 2/4/22, the Facility Consultant initiated an audit of care plans for all residents with wounds. This audit is to ensure resident is care planned for type and location of wound and skin interventions to include but not limited to lymphedema sleeves. The MDS and/or DON will address all concerns identified during the audit. Audit will be completed by 2/15/22. On 2/8/22, the Director of Nursing initiated an in-service with all nurses in regards to Care Plans. Emphasis is on ensuring care plan is updated timely and accurately with all aspects of resident care to include but not limited to type/location of wounds, skin/wound interventions to include but not limited to use of lymphedema sleeves and medications to include but not limited to IV therapy/antibiotics. In-service will be completed by 2/15/22. After 2/15/22, any nurse who has not completed the in-service will complete in-service upon next scheduled work shift. All newly hired nurses will be in-serviced during orientation in regards to Care Plans. The Nurse Supervisor and MDS nurse will review care plans for 10% of residents to	

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F 657	Continued From page 3 Physician orders revealed on 12/13/2021 vascular services was ordered for Resident #2 for intravenous (IV) antibiotics. On 12/14/2021, Ertapenem Sodium Solution one gram intravenously every twenty-four hours for seven days was ordered for Resident #2 for a urinary tract infection. The December 2021 Medication Administration Record (MAR) revealed Resident #2 received IV antibiotics from 12/14/21 to 12/20/2021. The MAR revealed no IV site monitoring or dressing changes. Nursing documentation dated 12/14/2021 revealed vascular services started an intravenous catheter in Resident #2's right arm. On 12/22/2021 nursing documentation revealed the intravenous catheter was intact and the completion of intravenous antibiotics. The annual Minimum Data Set (MDS) assessment dated 12/23/2021 indicated Resident #2 received intravenous medications. The care plan dated 1/12/2022 revealed Resident #2 was at risk for recurrent urinary tract infections and interventions included to administer medication as ordered by the physician. There was no plan of care for intravenous therapy on the care plan dated 1/12/2022 or the previous care plan dated 10/4/2021. On 1/14/2022 at 4:43 p.m. in an interview with Nurse #1, she stated she removed the IV catheter on 12/27/2021 and did not document the removal of the IV catheter in Resident #2's electronic medical record.	F 657	include resident #1 and #2 weekly x 4 weeks then monthly x 1 month utilizing the Care Plan Audit Tool. This audit is to ensure care plans updated timely and accurately for residents with wounds to include to type/location of wounds, skin/wound interventions to include but not limited to use of lymphedema sleeves and for residents on IV therapy and/or IV antibiotics. The assigned nurse, Nurse Supervisor, wound care nurse and MDS nurse will address all concerns identified during the audit to include updating care plans and/or re-training of staff. The Director of Nursing will review and initial the Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns identified. The Director of Nursing will forward the results of the Care Plan Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The Executive QA Committee will meet monthly x 2 months and review the Care Plan Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 657	Continued From page 4 On 1/14/2022 at 5:40 p.m. in an interview with the MDS nurse, she stated she updated care plans with the scheduled quarterly and annual MDS assessments, and nurses updated the care plans based on orders between the scheduled MDS assessments. She stated intravenous (IV) therapy was not included on the care plan after 12/23/2021 because Resident #2 had completed her IV therapy prior to 12/23/2021 MDS assessment.. On 1/14/2022 at 5:43 p.m. in an interview with Nurse #2, she stated IV therapy was not included on Resident #2's care plan. She stated she activated the order for the IV therapy on 12/13/2021 and should have updated the care plan. On 1/14/2022 at 5:45pm in an interview with the Director of Nursing, she stated care plans were updated quarterly, annually and when treatment plans or resident's condition changed. She stated resident's care plans should be updated when there was a new order for IV therapy.	F 657		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		2/15/22

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F 684	Continued From page 5 Based on record review and staff interviews, the facility failed to document weekly skin assessments on vascular wounds that included staging, measurements, drainage, pain, and assessment of the wound bed and surrounding tissue for 1 of 1 resident reviewed for wound care. (Resident #1) Finding included: Resident #1 was admitted to the facility on 9/21/2021. His diagnoses included peripheral vascular disease and ulcerations to the left lower extremity. The care plan dated 9/22/2021 indicated Resident #1 had actual venous stasis ulcerations to both lower legs, and interventions included documenting weekly evaluations and assessments of the ulcerations. The admission Minimum Data Set (MDS) assessment dated 9/27/2021 indicated Resident #1 was moderately cognitively impaired, required extensive assistance of one person with his activities of daily living except for eating and personal hygiene and the presence of vascular ulcerations. Resident #1's wound assessment dated 12/8/2021 identified three vascular wounds on the right lower extremity and two vascular wounds on the left lower extremity. The wound assessment recorded measurements for each vascular wound and documented a red wound bed with an odorless heavy serosanguinous drainage. There were no further wound assessments documented in Resident #1's electronic medical record from 12/8/221 to 1/14/2022.	F 684	F684 Quality of Care On 1/17/22, the Director of Nursing assessed resident #1 bilateral venous stasis ulcers to include measurements and description of the wound bed and surrounding tissue, treatment and notification of the physician and resident representative with documentation in the electronic record. On 1/15/22, the assigned hall nurses initiated a 100% skin audit of all residents. This audit was to identify any resident with skin/wound concerns and to ensure resident was assessed per facility protocol to include staging, measurements and description of the wound bed and surrounding tissue, treatment initiated and notification of the physician and resident representative with documentation in the electronic record. The Director of Nursing will address all concerns identified during the audit to include assessment of the resident to include location of the wound, staging when indicated, measurements and description of the wound bed and surround tissue, treatment initiated, notification of the physician and resident representative with documentation in the electronic record. Audit will be completed by 2/15/22. On 2/4/22, the Facility Consultant initiated an audit Wound Ulcer Assessments of all residents with wounds. This audit was to ensure Wound Ulcer Assessment was completed per facility protocol with to include staging, measurements and	

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F 684	Continued From page 6 On 12/19/2021, nursing documentation revealed both legs of Resident #1 were red, swollen and drainage that was foul smelling. The physician was called, and Resident#1 was started on antibiotics and was scheduled for the wound care clinic on 12/21/2021. On 1/14/2022 at 12:38 p.m. in an interview with Nurse #1, she stated she had served as the wound nurse for the facility until 1/12/2022. She stated wound assessments were scheduled weekly on Wednesdays and stated she had not been able to assess the wounds for the last four weeks because she was assigned to a medication cart. She stated she did not know who was performing the assessments. On 1/14/22 at 4:19 p.m. in an interview with the former Director of Nursing, she stated the wound assessments were conducted on Tuesday or Wednesday weekly by the wound nurse, and the wound nurse was available to complete the wound assessments. She stated if the wound nurse was not available, another nurse would had been delegated to conduct the weekly wound assessments. On 1/14/2022 at 4:50 p.m. in an interview with the Director of Nursing, she stated the wound nurse was to evaluate the wounds weekly and documented the wound assessment in the electric medical record	F 684	description of the wound bed and surrounding tissue, treatment initiated and notification of the physician and resident representative with documentation in the electronic record. The DON will address all concerns identified during the audit to include completing assessment per facility protocol with documentation in the electronic record to include staging when indicated, measurements and description of the wound bed and surrounding tissue, treatment initiated and notification of the physician and resident representative. Audit will be completed by 2/15/22. On 1/17/22, the facility consultant initiated an in-service with all nurses in regards to Wound Process with emphasis on skin referrals, assessment of wounds to include staging, measurements and description of wound bed and surrounding areas, wound treatment protocols, notification of MD/RR and updating care plans. In-service will be completed by 2/15/22. After 2/15/22, any nurse who has not completed the in-service will complete in-service upon next scheduled work shift. All newly hired nurses will be in-serviced during orientation in regards to Wound Process. The Director of Nursing will review 10% of residents with wounds to include resident #1 utilizing the Wound Care Audit Tool weekly x 4 weeks then monthly x 1 month. This audit is to ensure all wounds have been assessed per facility protocol with documentation in the Wound Ulcer Flowsheet, initiation of treatment per	

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F 684	Continued From page 7	F 684	wound protocol or MD orders, updating care plan and that the MD/RR were notified of wound status. The Director of Nursing will address all areas of concern identified during the audit to include assessing resident, initiating treatment per MD orders or wound protocol, completing assessments, updating care plan and notification of MD/RR. The Administrator will review and initial the Wound Care Audit Tool weekly x 4 weeks to ensure all areas of concern were addressed. Administrator will forward the Wound Care Audit Tool to the Executive QAPI Committee monthly x 2 months. The Executive QAPI Committee will review Wound Care Audit Tool monthly x 2 months to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based record review and staff interviews, the facility failed to remove a peripheral intravenous catheter after intravenous therapy was completed for 1 of 2 residents reviewed for intravenous (IV)	F 694	F694 Parenteral/IV Fluids On 12/27/21, the assigned nurse discontinued IV access for resident #2 per	2/15/22

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F 694	Continued From page 8 therapy. (Resident #2) Findings included: The facility's "Removal of a Peripheral Intravenous Catheter" dated 1/2008 stated a catheter should be removed when therapy was completed, during routine site rotation and when contamination or complications was suspected. Resident #2 was admitted 12/20/2020 to the facility. Her diagnoses included dementia and urinary tract infection. Physician orders revealed on 12/13/2021 vascular services was ordered for Resident #2 for intravenous antibiotics. On 12/14/2021, Ertapenem Sodium Solution one gram intravenously every twenty four hours for seven days was ordered for Resident #2 for a urinary tract infection. The December 2021 Medication Administration Record (MAR) revealed Resident #2 received IV antibiotics from 12/14/21 to 12/20/2021. Nursing documentation dated 12/22/2021 revealed the intravenous catheter was intact and intravenous antibiotics was completed. There were no nursing documentation indicating when the intravenous catheter was removed. The annual Minimum Data Set (MDS) assessment dated 12/23/2021 indicated Resident #2 received antibiotics for four days and intravenous therapy. The care plan dated 1/12/2022 revealed Resident #2 was at risk for recurrent urinary tract infections	F 694	physician order. On 1/17/22, the Director of Nursing completed an audit of all orders for IV therapy to include IV antibiotics for the past 30 days. This audit was to ensure IV access was discontinued upon completion of IV therapy/antibiotic as directed by the physician. The Director of Nursing and assigned hall nurse will address all concerns identified during the audit to include clarifying IV therapy orders when indicated for stop date and discontinuing IV access as directed by the physician. On 1/17/22, the Director of Nursing initiated an in-service with all nurses in regards to Intravenous Therapy with emphasis on removing IV catheter after IV therapy/antibiotics completed as directed by the physician and/or clarification of physician order when indicated to include a stop date. In-service will be completed by 2/15/22. After 2/15/22, any nurse who has not completed the in-service will complete in-service upon next scheduled work shift. All newly hired nurses will be in-serviced during orientation in regards to Intravenous Therapy. The Minimum Data Set Nurse will audit all residents with newly written IV therapy/antibiotic orders utilizing the Intravenous Therapy Audit Tool weekly x 4 weeks then monthly x 1 month. This audit is to ensure IV therapy/antibiotics was administered per physician order and IV access was discontinued upon completion of IV therapy/antibiotic as directed by the	

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F 694	Continued From page 9 and interventions included to administer medication as ordered by the physician. There was no plan of care for intravenous therapy on the care plan dated 1/12/2022 or the previous care plan dated 10/4/2021. On 1/14/2022 at 4:43 p.m. in an interview with Nurse #1, she stated she was not the assigned nurse when Resident #2 completed her intravenous antibiotics. She stated intravenous catheters were discontinued at the end of therapy and did not know why the IV catheter had not been removed. Nurse #1 stated she removed the IV catheter on 12/27/2021 and did not document the removal of the IV catheter in Resident #2's electronic medical record. She stated the site of the IV catheter was not red or swollen when the IV catheter was removed. On 1/14/2021 at 4:50 p.m. in an interview with the Director of Nursing, she stated IV catheters should to be removed at the end of IV therapy.	F 694	physician. The MDS nurse and Nurse Supervisor will address all concerns identified during the audit to include clarification of physician to include stop date, removing IV access when indicated and re-training of staff. The DON will review and initial the Intravenous Therapy Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. DON will forward the Intravenous Therapy Audit Tool to the Executive QAPI Committee monthly x 2 months. The Executive QAPI Committee will review Intravenous Therapy Audit Tool monthly x 2 months to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §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	F 842		2/15/22

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F 842	Continued From page 10	F 842		

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.

§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.

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	345313	A. BUILDING _____ B. WING _____	C 01/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 11 §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, resident interview and staff interview, the facility failed to accurately document the application of lymphedema sleeves as physician ordered when the lymphedema sleeves were not available in the facility for 1 of 1 resident. (Resident #1) Findings included: Resident #1 was admitted to the facility on 9/21/2021. His diagnoses included peripheral vascular disease and ulcerations to the left lower extremity. The care plan dated 9/22/2021 indicated Resident #1 had actual venous stasis ulcerations to both lower legs, and interventions included treatments as ordered by the physician. The admission Minimum Data Set (MDS) assessment dated 9/27/2021 indicated Resident #1 was moderately cognitively impaired and the presence of vascular ulcerations. Physician orders dated 11/17/2021 revealed an	F 842	F842 Resident Records-Identifiable Information On 1/31/22, the Director of Nursing reviewed Treatment Administration Record (TAR) for resident #1 from 1/17/22-1/31/22 to ensure Lymphedema sleeves applied per physician order and documented accurately on the TAR. No other concerns identified. On 1/27/22, the Director of Nursing initiated an audit of all treatment orders to include but not limited to lymphedema sleeves. This audit is to ensure the facility had appropriate treatment supplies available to complete treatments per physician orders. The DON will address all concerns identified during the audit to include obtaining supplies as indicated or notification of the physician for further instructions when supplies are not available. Audit will be completed by 2/15/22. On 2/3/22, the Director of Nursing initiated an audit of all current orders for residents	

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F 842	Continued From page 12 order for the application of lymphedema sleeves for Resident #1 to both legs twice a day for one hour to decrease edema. There was no order to hold lymphedema sleeves for Resident #1. Nursing documentation indicated the lymphedema sleeves were not available in the facility in November 2021 and December 2021. Nursing documentation revealed on 12/21/2021, the physician held application for lymphedema sleeves for Resident #1 until lymphedema sleeves were available. The December 2021 Treatment Administration Record (TAR) indicated lymphedema sleeves were applied as ordered twice a day for thirteen days out of the first twenty days of December and once a day on four days of the first twenty days in December. On December 21, 2021, the MAR indicated the order for lymphedema sleeves was held for seven days. Nursing documentation for January 2022 indicated lymphedema sleeves were unavailable at the facility and until 1/11/2022 at 6:00 p.m. when nursing documentation revealed lymphedema sleeves were applied to Resident #1's legs. The January 2022 TAR for Resident #1 recorded lymphedema sleeves were applied six days of the first eleven days in January 2022 when the lymphedema sleeves were not available. On 1/14/2022 at 2:08 p.m. in an interview with Nurse #1, she stated Resident #1's lymphedema sleeves were not available at the facility in December 2021 and arrived at the facility last week. She stated she documented on the	F 842	attending wound clinic. This audit is to ensure the facility is following wound clinic recommendations in regards to treatments and wound interventions. The DON will address all concerns identified during audit to include clarifying orders when indicated. Audit will be completed by 2/15/22. On 2/8/22, the Facility Consultant completed an audit of TAR from 2/1/22-2/7/22. This audit is to identify any treatment not completed per physician order or documented accurately when provided. The DON will address all concerns identified during the audit to include assessment of the resident, notification of the physician of the physician and/or education of staff. Audit will be completed by 2/15/22. On 1/17/22, the Director of Nursing initiated an in-service with all staff in regards to TAR Documentation with emphasis on ensuring timely and accurate documentation of treatments when completed and/or notification of the physician for further instructions when supplies are not available. In-service will be completed by 2/15/22. After 2/15/22, any nurse who has not completed the in-service will complete in-service upon next scheduled work shift. All newly hired nurses will be in-serviced during orientation in regards to TAR Documentation. The IDT team to include MDS nurse, Administrator, Charge Nurse and Staff	

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F 842	Continued From page 13 December 2021 TAR lymphedema sleeves were applied as ordered when the lymphedema sleeves were not available to apply to Resident #1. She stated she documented the lymphedema sleeves were applied because other nurses had documented lymphedema sleeves were applied. She stated the Director of Nursing informed the nursing staff application of lymphedema sleeves could not be documented, and an order was received to hold the application of the lymphedema sleeves. On 1/14/2022 at 2:35 p.m. in an interview with Resident #1, he stated the lymphedema sleeves arrived at the facility on Monday 1/10/2022, and he had been wearing the lymphedema sleeves every day since Tuesday 1/11/2022. On 1/14/2022 at 3:40 p.m. in an interview with the central supply manager, she stated the facility was not able to locate a supplier with lymphedema sleeves for Resident #1. She stated the lymphedema sleeves arrived at the facility during the first part of January 2022. She was not able to provide an exact date on the arrival of the lymphedema sleeves. On 1/14/2022 at 4:19 p.m. in an interview with the former Director of Nursing (DON), she stated she was not aware the facility was not able to receive lymphedema sleeves for Resident #1. Upon learning Resident #1 did not have lymphedema sleeves available at the facility and the TAR indicated nursing documentation of application of lymphedema sleeves, she conducted in-services on documentation of care with the nursing staff. She stated nursing staff cannot document resident care as given when it was not provided.	F 842	Facilitator will review TAR documentation 5 times a week x 4 weeks then monthly x 1 month utilizing the TAR Administration Report. This audit is to ensure treatments are completed per physician order with accurate documentation on the TAR. The MDS nurse, Charge Nurse and/or Staff Facilitator will address all concerns identified during the audit to include assessment of the resident, completion of treatment as ordered, notification of the physician and/or re-training of staff. The DON will review and initial the TAR Administration Report 5 times a week x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Staff Facilitator will audit treatment orders weekly x 4 weeks then monthly x 1 month utilizing the TAR Supply Audit Tool. This audit is to ensure the facility had appropriate treatment supplies available to complete treatments per physician orders. The Staff Facilitator and Charge Nurse will address all concerns identified during the audit to include ordering supplies or notification of physician for further instructions when supplies not available. The DON will review the TAR Supply Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns addressed. DON will forward the TAR Administration Report and TAR Supply Audit Tool to the Executive QAPI Committee monthly x 2 months. The Executive QAPI Committee will review TAR Administration Report and TAR Supply Audit Tool monthly x 2 months to determine trends and / or	

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F 842	Continued From page 14 On 1/14/2022 at 4:50 p.m. in an interview with the DON, she stated resident care was documented on the Medication Administration Record (MAR) and Treatment Administration Record (TAR). She stated codes were available to document on the MAR and TAR why resident care was not given as ordered and nurses could document reasons in the nurse notes also. She stated nursing staff should not document resident care as given on the MAR or TAR that was not provided.	F 842	issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	