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	345129	A. BUILDING _____ B. WING _____	C 01/27/2022

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DAVIE NURSING AND REHABILITATION CENTER	498 MADISON ROAD MOCKSVILLE, NC 27028

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E 000	Initial Comments An unannounced recertification survey was conducted on 1/24/22 to 1/27/22. The facility was found in compliance with CFR 483.73, Emergency Preparedness. Event ID# CGK311.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 01/24/22 through 1/27/22. Event ID# CGK311 2 of 3 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		2/22/22

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

Electronically Signed | 02/18/2022

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, resident representative interview, staff interviews and record reviews, the facility failed to treat residents in a dignified manner during dining by standing over a resident while assisting the resident with eating (Resident #60); and when a staff member entered a resident's room (Resident #80) without knocking or asking permission to enter for 2 of 8 residents reviewed for dignity. 1. Resident #60 was admitted to the facility on 7/12/21. The significant change assessment dated 1/18/22 indicated Resident #60 was severely cognitively impaired. The care plan dated 1/24/22 revealed Resident #60 was at risk for nutritional/hydration alterations. Interventions included: provide	F 550	This plan of correction constitutes our written plan of compliance for deficiencies cited; however, submission of the plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal laws. Resident # 80 and #60 still resides in the facility and has had no negative outcomes related to staff not knocking on their door prior to entering or being fed while staff was standing. All residents have the ability to be affected by staff not knocking on their door or announcing themselves prior to entering. All residents that require feeding assistance have the ability to be affected	

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F 550	Continued From page 2 assistance with meals as needed to encourage intake. During a dining observation on 01/24/22 at 01:49 p.m., Nursing Assistant (NA#4) was assisting Resident #60 with feeding while standing over him as he reclined in his bed which was in a lowered position. NA#4 revealed she usually sat in a chair (pointed to a chair next to the roommate's bed) when feeding Resident #60. Throughout the dining observation, NA#4 continued to stand while assisting the resident with feeding in his room. During an interview on 01/27/22 at 09:41 a.m., Supervisor Nurse #1 stated that NA#4 should not have been feeding the resident while standing over him. 2. Resident #80 was admitted to the facility on 7/16/20 with diagnoses that included, in part, dementia. The annual Minimum Data Set assessment dated 12/29/21 revealed Resident #80 had moderately impaired cognition. She required extensive assistance with eating. On 1/24/22 at 12:36 PM Nurse Aide (NA) #3 was observed when she delivered a meal tray to Resident #80. The door to the room was open. NA #3 entered the resident's room without knocking on the door or announcing her presence. NA #3 provided assistance with eating to Resident #80 and at 12:53 PM removed the resident's tray and exited the room. At 12:56 PM, NA #3 obtained a nutritional supplement for Resident #80, then re-entered her room and dropped off the supplement without knocking on	F 550	by staff not feeding them at eye level. When it was brought to the facilities attention, DON, ADON and unit manager immediately educated all staff currently in the building on knocking on resident□s doors and dignity while feeding. At the next meal service, on 1/24/2022, the DON, ADON, and Unit Manager rounded to ensure that all staff assisting residents were sitting while feeding. To prevent this from recurring, all staff will be educated by the Administrator or designee on the resident bill of rights by 2/18/22. All new staff as of 2/19/22, and all agency employees will be educated on resident rights in orientation. During routine rounds, department heads will monitor for staff knocking doors before entering rooms and announcing themselves before entering. Department heads will also monitor for staff sitting while feeding residents. To monitor and maintain ongoing compliance beginning 2/21/22 Administrator or designee will monitor 10 staff per week entering resident rooms for appropriately knocking on the door or announcing themselves for 12 weeks To monitor and maintain ongoing compliance, Administrator or designee will monitor 10 resident□s per week for 12 weeks to ensure that staff are seated	

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F 550	Continued From page 3 the door or announcing her presence. NA #3 returned to the room a third time, at 12:57 PM and provided a straw to the resident. She entered Resident #80's room without knocking on the door or announcing her presence. An interview was completed with NA #3 on 1/24/22 at 1:05 PM, during which she stated prior to entering a resident's room staff were supposed to knock on the door. NA #3 shared sometimes she just walked into a resident's room if the door was open and announced her presence as she walked into the room. She acknowledged she should have knocked on Resident #80's door before she entered her room. Resident #80's representative was interviewed by phone on 1/25/22 at 9:23 AM. He thought in a traditional home environment Resident #80 would want a visitor to knock on her door before they entered her home or room. During an interview with the Director of Nursing (DON) on 1/27/22 at 9:41 AM, she explained when staff entered a resident's room they should either knock on the door or announce their presence before they entered the room. The DON said the facility routinely completed inservices with staff relating to resident rights and dignity and NA #3 should have knocked on the door or announced her presence before she entered Resident #80's room.	F 550	when giving feeding assistance. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. Administrator is responsible for compliance. Date of compliance is 2/22/2022.	
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that	F 554		2/22/22

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F 554	Continued From page 4 this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews and record review, the facility's interdisciplinary team failed to assess and document the ability of a resident to self-administer medications for 1 of 1 resident (Resident #46) who was observed to have medications at bedside. Findings included: Resident #46 was admitted to the facility on 9/8/20 with diagnoses that included, in part, diabetes, osteoporosis and Parkinson's disease. The annual Minimum Data Set assessment dated 11/25/21 revealed Resident #46 was cognitively intact. Physician (MD) orders were reviewed and included an order dated 1/4/22 for PreserVision (a multi-vitamin), one capsule by mouth, one time a day at the bedside, and an order dated 1/4/22 for Prevagen (a supplement to help with memory), one capsule by mouth, one time a day at the bedside. Further review of the medical record revealed no assessments were completed for the self-administration of medications. An observation and interview were conducted with Resident #46 on 1/24/22 at 10:48 AM. A bottle of PresserVision, and a bottle of Prevagen were observed to be placed within the resident's reach on the overbed table. During an interview with Resident #46, she stated she wanted to have the medications at her bedside, had permission to self-administer the medications and the facility	F 554	Resident #46 still resides in the facility and has no negative outcomes from self-administering her PreserVision and Prevagen. Resident□s ability to safely administer medications assessment was completed on 1/26/22. All residents who wish to self-administer medications have the ability to be affected. Audit was conducted of current residents as of 2/14/22, 3 additional residents wish to self-administer certain medications. DON discussed with provider, orders obtained to self-administer and Resident□s Ability to Safely Self Administer Medications Assessment completed. To prevent this from recurring, all nurses will be educated by 2/18/22 by the DON or designee on the facility policy for resident self-administration of medications. Providers educated to inform nursing management of any orders written to self-administer medication All orders to be reviewed during clinical morning meeting for self-administration of medications and completion of the Resident□s ability to safely administer medications assessment. To monitor and maintain ongoing	

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F 554	Continued From page 5 had completed an evaluation of her to self-administer the medications. On 1/27/22 at 9:16 AM a phone interview was completed with Nurse #5. She entered the orders in the electronic health record for Resident #46 to self-administer medications of PreserVision and Prevagen. She explained if a resident wanted medications kept at bedside there was a self-administration of medications form that was completed by the nurse before the medications were left at the bedside. Typically, the nurse notified the MD of the resident's request to self-administer medications, obtained the order and completed the assessment. Nurse #5 said she had not completed the self-administration of medication assessment because she thought either the MD or nurse practitioner (NP) had completed the form. During interviews with the Director of Nursing (DON) on 1/26/22 at 11:25 AM and on 1/27/22 at 9:35 AM, she explained if a resident requested medications be kept at the bedside, the facility assessed the resident's competence to self-administer medications and obtained an order from the MD for medications to be kept at bedside. The DON said the NP had assessed Resident #46 and validated the resident was competent to have medications at bedside but did not "properly document." Since there was no assessment documented, Nurse #5 should have completed the assessment to self-administer medications after she received the order from the NP.	F 554	compliance, beginning 2/21/22 and continuing for 12 weeks, DON or designee will audit 5 residents orders weekly to self-administer medications for the completion of the Resident s ability to safely administer medications, audit 5 resident rooms per week to ensure that there are no medications left at bedside without the appropriate order and assessment, and perform 5 resident interviews per week to ensure that no other resident desires to self-administer medication. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. Administrator is responsible for compliance. Date of compliance is 2/22/22.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		2/22/22

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F 641	Continued From page 6 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to accurately code the Pre-Admission Screening and Resident Review (PASRR) on the comprehensive Minimum Data Set (MDS) assessment for 1 of 3 residents (Resident #28) reviewed for PASRR. Findings included: Resident #28 was admitted to the facility on 1/8/20. Diagnoses included, in part, bipolar disorder and schizophrenia. The North Carolina Medicaid Uniform Screening Tool (a computer program used to apply for PASRR numbers) was reviewed with the facility Social Worker (SW) on 1/26/22 at 9:25 AM and specified Resident #28 had a level two PASRR determination that was effective 3/12/20. The comprehensive MDS assessment dated 11/14/21 did not indicate Resident #28 had a level two PASRR determination. During an interview with the SW on 1/26/22 at 11:18 AM, she reported she coded the PASRR on the MDS assessments. She explained she routinely looked in the "miscellaneous section" in the resident's electronic health record (EHR) for PASRR information which was where PASRR determination notices were scanned into the chart. The SW said the PASRR determination notice was not uploaded into the EHR so she didn't see that Resident #28 had a level two	F 641	The MDS assessment for resident #28 is now Level II which is consistent with PASRR and is coded appropriately. The resident did not have any negative outcomes from this occurrence. To identify other residents who have the potential to be affected, all residents in facility as of 2/15/2022 that have intellectual disabilities or serious mental illness were audited to ensure that their MDS assessment is consistent with their PASRR. Any identified residents needing an update were acted upon and their MDS will be corrected to reflect accurate PASRR levels. To prevent this from recurring, the facility Social Worker and Admissions Department were educated by the Saber Community Support For Social Services Director regarding the process for applying for PASRRs and the requirement for accurate coding on the MDS on 2/16/2022. Prior to submission of MDS, the Social Worker will validate accurate coding for PASRR status. To monitor and maintain ongoing compliance beginning the week of 2/21/2022, the facility administrator will audit three residents per week for 12	

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F 641	Continued From page 7 PASRR determination. On 1/27/22 at 9:45 AM an interview was completed with the Administrator. He said the facility staff missed a step in the coding process and the PASRR determination notice was not scanned into the computer system. He added the corporate office assisted with training and monitoring related to MDS accuracy.	F 641	weeks to ensure proper coding on the MDS assessment to reflect current PASRR status. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations for the duration of the auditing. Administrator is responsible for compliance. Date of compliance is February 22, 2022.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	F 644	Resident #65 had a new PASRR updated	2/22/22

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F 644	Continued From page 8 facility failed to ensure a resident assessment for a Level II PASRR (Preadmission Screening and Resident Review) was completed for 1 of 3 sampled residents (Resident #65) reviewed for Level II PASRR. Findings included: Review of Resident #65's admitting Minimum Data Set (MDS) dated 9/27/21 revealed that Resident #65 had been admitted to the facility from the hospital with diagnoses of bipolar disorder with psychosis. Review of the PASRR Level I Determination Notification letter dated 6/9/2021 revealed that "No further PASRR screening is required unless a significant change occurs with the individual's status which suggests a diagnosis of mental illness or mental retardation, or if present, suggests a change in treatment needs for those conditions." Review of Resident #65's PASRR Level 1 Screen paper application dated 6/9/2021 revealed that the previous facility indicated that he had no mental health diagnoses. In an interview on 1/25/22 at 3:00 PM, the Social Worker stated that Resident #65 was admitted to the facility from the hospital and the facility had scanned in his PASRR Determination Notification letter that stated he did not need a Level 2 upon admission. She stated that she was unaware of the possibility that the previous facility may have completed the initial PASRR application incorrectly and added that she does not routinely check the letters for accuracy.	F 644	by social worker. New PASRR is now Level II. The resident did not have any negative outcome from this event. To identify other residents who have the potential to be affected, all residents in facility with diagnosis of intellectual disabilities or serious mental illness as of 1/27/2022 were audited to ensure proper diagnoses were submitted for current PASRR. Any identified residents needing an update were acted upon and new PASRR applications are being submitted. To prevent this from recurring, the facility Social Worker and Admissions Department were educated by the Saber Community Support for Social Services regarding the process for applying for PASRRs on 2/16/2022. Weekly PASRR meetings will be conducted to ensure new admits and current residents with new diagnoses have new PASRRs applied for as needed and that the care plans properly reflect their PASRR status. To monitor and maintain ongoing compliance beginning the week of 2/21/2022, the facility administrator will audit three residents per week for 12 weeks that are admitted to determine that residents with a diagnosis of intellectual disabilities or serious mental illness have appropriate PASRR levels and if the resident does not have the appropriate level, that a new PASRR has been applied for. The facility social worker will review 3	

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F 644	Continued From page 9 In an interview on 1/26/22 at 2:30 PM the Administrator stated he was unaware that the facility could be accountable for incorrect data being entered by another facility resulting in a Level 2 not being completed for a resident prior to him or her be admitted to the facility. He added that the facility will begin screening for this with every current resident and new admission.	F 644	resident charts per week for 12 weeks to ensure that there has not been a significant change that would require a PASRR referral. These results will be documented on an audit tool. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations for the duration of the auditing. Administrator is responsible for compliance. Date of compliance is February 22, 2022.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interview and record review, the facility failed to renew an order for anti-fungal powder for 1 of 1 resident (Resident #46) who was observed to have medications at bedside. Findings included: Resident #46 was admitted to the facility on 9/8/20 with diagnoses that included, in part, diabetes. The annual Minimum Data Set assessment dated	F 658	Resident #46 still resides in the facility. She states that she wishes to continue to use this medication as needed and keep at bed-side. 1/26/22 order was obtained for Nystatin powder PRN may self-administer and leave at bedside. To identify other residents who have the potential to be affected, an audit was conducted on 2/17/22 of all residents with skin impairments to ensure the services provided by the facility based on the care plan were implemented including active	2/22/22

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F 658	Continued From page 10 11/25/21 revealed Resident #46 was cognitively intact. She needed supervision to extensive assistance with activities of daily living (ADLs). She was coded as having no skin issues and she received application of ointments/medications other than to feet. The care plan, updated 12/9/21, revealed focused areas of ADLs and skin. Interventions included, "Resident will have the ability to perform or be assisted with hygienic measures, such as proper hand washing, and administer medications as ordered by physician." Physician (MD) orders were reviewed and included an order dated 12/9/21 for Nystatin powder (an anti-fungal medication), 100,000 unit/gram, apply to redness topically in the evening for yeast. The order for the Nystatin powder was discontinued on 12/18/21. Observations and interviews were conducted with Resident #46 on 1/24/22 at 10:48 AM and on 1/26/22 at 1:50 PM. A bottle of anti-fungal powder was observed to be placed within the resident's reach on the overbed table. During an interview with Resident #46, she stated the facility gave her the anti-fungal powder "over six months ago" and explained she applied the powder when she experienced moisture on her skin or if she "felt raw." She said she had permission to self-administer the powder which she used on an as needed basis and the last time she used it was three weeks ago. During an interview with the Director of Nursing (DON) on 1/27/22 at 9:35 AM, she stated Resident #46 had skin impairment and yeast and the Nurse Practitioner (NP) placed her on Nystatin powder. The DON thought the skin issues resolved and the powder was	F 658	orders for treatment. To prevent this from recurring, DON or designee will educate nurses and MDS coordinators on ensuing that resident care plans and active orders are obtained and in place for skin care needs. This education will be completed by 2/18/22. Beginning 2/19/22 all new nurses, MDS coordinators and agency staff will be educated on the same expectation. To monitor and maintain ongoing compliance, beginning 2/21/22 DON or designee will audit 10 residents weekly for 12 weeks for skin impairments, orders for skin impairments and accurate updating of care plan. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. Administrator is responsible for compliance. Date of compliance is 2/22/22	

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F 658	Continued From page 11 discontinued. The DON explained staff should have removed the powder from Resident #46's room when the order was discontinued or if the resident felt she still needed it then staff should have obtained a new order for the resident to use the powder as needed.	F 658		
F 675 SS=D	Quality of Life CFR(s): 483.24 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and staff interviews the facility failed to ensure Resident #63 was positioned upright in bed while eating during 1 of 2 dining observations. The findings included: Resident #63 was originally admitted to the facility on 3/14/14 and re-admitted on 12/9/21 with diagnoses which included: cerebral infarction, diabetes mellitus, dysphagia, aphasia and gastroesophageal reflux disease. The quarterly assessment dated 12/15/21 indicated Resident #63 was cognitively impaired with a communication deficit and required	F 675	Resident #63 still resides in the facility and has had no negative outcomes related to not properly being positioned during a meal. Resident was immediately repositioned properly for the remainder of her meal as soon as it was brought to the attention of the supervisor that she was not positioned correctly. All residents that requires positioning assistance with meals have the potential to be affected 1/27/22 ADON and unit manager did a complete walk through of the facility during the next meal service and ensured all residents were positioned correctly. All	2/22/22

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F 675	Continued From page 12 extensive assistance with eating due to coughing/choking during meals. The care plan dated 12/15/21 revealed Resident #63 was at risk for nutritional/hydration alterations. Interventions included: Monitor for signs and symptoms of aspiration; speech therapy screen, when necessary; and encourage adequate fluid intake. On 1/27/22 at 9:01 a.m., Resident #63 was observed reclined in her bed with the head of the bed raised at an approximate angle of 40 degrees. The resident was attempting to feed herself from her meal tray which was on the overbed table positioned across her lap but raised so that the resident had to reach up to reach the food items on the meal tray. A return visit to Resident #63's room was made on 1/27/22 at 9:05 a.m., accompanied by Supervisor Nurse #1 who observed and acknowledged Resident #63 was not positioned correctly in her bed while feeding herself. She confirmed the nursing assistant (NA) should have raised the head of the resident's bed upright and repositioned the resident so she could look down at the food items on the meal tray. Supervisor Nurse #1 removed the overbed table and explained to the resident she needed to reposition her so that she (Resident #63) could see the food on her tray, but she would need staff assistance. Supervisor Nurse #1 left the resident's room and returned with NA #5 who assisted the nurse with repositioning the resident and raising the head of the bed at an approximate 85-degree angle. Throughout this process the nurse educated NA #5 on the risk of Resident #63 aspirating on a food item when eating in a	F 675	current staff working were verbally educated about proper positioning for meals. To prevent this from recurring, DON or designee will re-educate nursing staff on proper positioning with meals by 2/18/22 Beginning 2/19/22 all new hires and agency staff who are responsible for positioning residents during meals will receive this education. During routine rounds, department heads will monitor for staff knocking doors before entering rooms and announcing themselves before entering. Department heads will also monitor for staff sitting while feeding residents. To monitor and maintain ongoing compliance, DON or designee beginning 2/21/22 will audit 10 residents at meal time for appropriate positioning per week for 12 weeks. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. Administrator is responsible for compliance. Date of compliance is 2/22/22.	

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F 675	Continued From page 13 reclined position. Before exiting the room, Supervisor Nurse #1 also instructed the NA#5 to sit in the chair next to the bed and assist the Resident #63 with completing her breakfast. During an interview on 1/27/22 at 9:15 a.m., NA #5 stated once she set up Resident #63's meal tray on the overbed table in front of her, she (NA) felt the was "ok" to feed herself because the resident could reach the food items on her meal tray. When asked if she (NA#5) had been educated about this resident's care, the NA#5 responded, "I don't remember". During an interview on 1/27/22 at 9:28 a.m., Supervisor Nurse #1 revealed Resident #63 recently returned from the hospital with the diagnosis of a stroke and was able to feed herself, but the nursing assistants were instructed to check in on her because she slows down while feeding herself and may need assistance. She stated that upon NA#5's arrival for duty that morning, she was educated about the care needed for Resident #63.	F 675		
F 684 SS=D	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		2/22/22

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F 684	Continued From page 14 Based on observations, record review and staff and wound physician interviews, the facility failed to follow a physician ' s order when providing care to a non-pressure wound for 1 of 4 residents reviewed for pressure ulcers (Resident #3). The findings included: The facility admitted Resident #3 to the facility on 10/27/2021 with diagnoses of, in part, peripheral vascular disease, diabetes mellitus type 2, diabetic polyneuropathy and absence of right foot. A quarterly Minimum Data Set assessment dated 01/12/2022 indicated Resident #3 required extensive assistance with bed mobility, dressing, toileting and hygiene. The resident was dependent for transfers and bathing, was non-ambulatory and incontinent of bowel and bladder. Resident #3 had 5 venous or arterial ulcers and received dressings to feet. The care plan included a focus area of actual skin impairment to left proximal foot. Interventions included treatments as ordered. Resident #3 ' s January 2022 physician ' s orders included clean left proximal foot with normal saline, apply calcium alginate and cover with dry dressing, kerlix and ace wrap daily. A wound assessment dated 01/19/2022 by the wound care physician revealed a full thickness arterial wound to Resident #3 ' s left proximal, lateral foot. The area measured 4.8 x 2 x 0.2 and had 100 % granulation tissue. The dressing treatment plan was to continue calcium alginate and wrap with kerlix and ace wrap for 15 days.	F 684	Resident #3 still resides in the facility and has had no negative outcome from the facility providing the incorrect treatment of his wound. Treatment nurse immediately re-dressed his wound with the appropriate dressing when it was brought to her attention that the wrong treatment was applied. All residents with wound orders have the ability to be affected. 1/26/22 Wound treatment nurse reviewed all other residents with wound dressings to ensure that the appropriate dressing was applied per physician□s order and there were no other findings. To prevent this from recurring, DON or designee educated all staff responsible for administering wound treatments on the facility policy of providing wound care by following physician orers by 2/18/22. Beginning 2/19/22 all new staff and agency staff who are responsible for wound care services will be educated to administer the treatment as ordered by MD. To monitor and maintain ongoing compliance, beginning 2/21/22 the DON or designee will observe 5 residents per week for 12 weeks for the appropriate application of wound treatments per physicians order. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations for the	

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F 684	Continued From page 15 On 01/26/2022 at 10:28 AM, an observation of Resident #3 ' s wounds was conducted by the Treatment Nurse. The Treatment Nurse removed the ace wrap and kerlix to Resident #3 ' s left foot. A dry dressing was observed over the left proximal wound with moderate reddish-brown drainage. The wound bed was observed to be beefy red and there was a small, blackened area noted. The wound was cleaned then the Treatment Nurse was observed to put medi-honey (a wound gel for dry to moderately exuding wounds) on the wound and cover the wound with an abdominal pad, wrapped it with kerlix and an ace wrap. On 01/27/2022 at 8:41 AM, an interview was conducted with the Treatment Nurse. When asked about the treatment provided to Resident #3 ' s left proximal foot, she stated the wound care physician must have changed the order and she was unaware medi-honey was not the order for the left proximal foot. On 01/27/2022 at 9:48 AM, a second interview was conducted with the Treatment Nurse who stated she checked Resident #3 ' s physician ' s orders and she did apply the wrong treatment to Resident #3 ' s left proximal foot. She stated she did check orders before she provided care but must have gotten confused. She added the resident has 3 areas on his left foot and they all have different orders for treatments. On 01/27/2022 at 1:36 PM, an interview was conducted with the wound care physician. He was away from his computer and could not recall Resident #3 ' s orders but stated medi-honey was used to add moisture to wounds. He stated the Treatment Nurse should have applied the correct	F 684	duration of the auditing. Administrator is responsible for compliance. Date of compliance is 2/22/22	

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F 684	Continued From page 16 treatment per the orders to Resident #3 ' s wound but the application of medi-honey would not have caused any harm to the resident.	F 684		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and physician interviews, the facility failed to 1. Assess and initiate a treatment for a new admission with a Stage 3 pressure ulcer for 1 of 3residents reviewed for pressure ulcers (Resident #294). The findings included: 1. A review of Resident #294 ' s hospital discharge summary dated 10/22/2021 revealed a stage 3 pressure ulcer to the sacrum that was present on admission and excoriation to the buttocks. Instructions for wound care were to off-load, apply a foam absorbent dressing and barrier cream.	F 686	Resident no longer resides in the facility. To identify other residents who have the potential to be affected, facility performed an audit of all newly admitted residents in the past week from 2/6/22-2/12/22. Skin has been reviewed and discharge paperwork reviewed for skin and wound orders. All appropriate treatments have been initiated. To prevent this from recurring, DON or designee will re-educate all nurses that they are to perform a head to toe assessment upon admission. If any skin impairments are noted they are to review	2/22/22

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F 686	Continued From page 17 The facility admitted Resident #294 to the facility on 10/22/2021 with diagnoses of congestive heart failure, atrial fibrillation, sepsis, acute kidney failure, open wound to lower back and pelvis, anemia, liver cirrhosis and bacterial peritonitis. The baseline care plan dated 10/22/2021 did not include a focus area of pressure ulcer presence. A nurse ' s note dated 10/22/2021 at 7:30 PM by Nurse #3 revealed Resident #294 arrived at his room. Sacral wound present. Dressings malodorous to right elbow and sacrum upon arrival, drainage present on both wounds. An admission skin assessment dated 10/22/2021 by Nurse #3 revealed a sacral wound present and an open wound to the right elbow. No other description was recorded. The assessment did not include the appearance of Resident #294 ' s buttocks. On 01/27/2022 at 2:50 PM, Nurse #3 was interviewed. She stated she was new to the facility and was working on 10/22/2021 when Resident #294 was admitted. She stated she did a head-to-toe assessment and saw that Resident #294 had a pressure ulcer to his sacrum. She stated he did not have a pressure ulcer to his buttocks. She stated she was told by the First Shift Supervisor not to worry about staging the wound and that was why she didn ' t describe it further in her documentation. She added she did not know why she did not put the treatment orders in place. A nurse ' s note dated 10/24/2021 at 5:20 PM by the Director of Nursing revealed Resident #294	F 686	the discharge summary for orders or inform the provider and obtain orders. This education will be completed by 2/18/22. All admissions will be reviewed by a 2nd nurse within 24 hours of admission for accurate transcription/implementation of treatment orders for skin impairments. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. Administrator is responsible for compliance. Date of compliance is 2/22/2022. Beginning 2/19/2022, all nurses and agency nurses will be educated on the same procedure. To monitor and maintain ongoing compliance, beginning 2/21/22 DON or designee will audit 5 new admissions per week for 12 weeks to ensure that admitting treatment orders were transcribed accurately and implemented as ordered.	

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had skin impairment and the physician was notified. No orders were given.

A physician ' s progress note dated 10/25/2021 at 1:30 PM indicated presence of a sacral wound. Plan was to continue wound care as ordered and wound physician to follow. Continue to offload pressure as much as resident will allow.

A nurse ' s note dated 10/25/21 at 3:57 PM by the Social Worker read "resident discharged home today per his own choice."

Resident #294 ' s physician ' s orders for October 2021 did not include treatment orders for the sacral wound, buttocks or elbow.

Resident #294 ' s Treatment Administration Record for October 2021 did not include wound care orders.

On 01/27/2022 at 8:46 AM, the Treatment Nurse was interviewed. She stated if a resident came in late on Friday and she has already left, the hall nurse or supervisor does the assessment. They are to do a head-to-toe assessment and document the wounds appearance. She would do the measurements on Monday when she returned to work. The admitting nurse should also put the treatment orders in. She stated Resident #294 was agitated and refused to allow her to assess his wound on Monday, 10/25/2021 because he wanted to leave so she never saw his wound.

On 01/27/2022 at 2:31 PM, the Director of Nursing was interviewed. She stated when a resident is admitted, the admitting nurse should do a head-to-toe assessment, take off all old dressings, look at all wounds, documents and

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F 686	Continued From page 19	F 686		

replace dressings. Documentation should include what the wounds look like including size and appearance. The admitting nurse doesn ' t have to stage the wound, that can be done by the Treatment Nurse the following day. She stated admitting nurse was expected to implement orders from the discharge summary. She didn ' t know why that didn ' t get done for Resident #294.

On 01/27/2022 at 3:05 PM, the First Shift Supervisor was interviewed. She stated she came on duty after Nurse #3 on 10/25/2021 and got report on Resident #294. She stated she observed the dressing to the resident ' s sacrum and did not note any foul odor. She stated she lifted the dressing to the sacrum and observed the wound and saw an open area. The wound dressing did not have a large amount of drainage. She added she did not change the dressing at that time because it had a foam dressing in place, and she didn ' t know what the orders were. She stated she did not put the treatment orders in because she thought Nurse #3 did it already.

On 01/27/2022 at 4:43 PM, the Second Shift Supervisor was interviewed. She stated she worked on 10/22/2021 when Resident #294 was admitted, and she was training Nurse #3. Nurse #3 did the assessment and she put in the orders. She stated Nurse #3 came to her and asked her what to do about the resident ' s wound and she told her to use the foam dressing that was ordered. Nurse #3 went to get the supplies and she changed the dressing. She stated she observed the wound also and the wound dressing was soiled on admission. She stated the resident had an open sacral wound and no other wounds on his bottom, but he did have some excoriation

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F 686	Continued From page 20	F 686		

to his buttocks. The Second Shift Supervisor added she was on call the following day, 10/23/2021 and she went to the facility to check on things. She stated she saw Resident #294 to check on him because she knew he was being difficult and wanting to leave the day before. She stated the wound dressing was intact, but he had a bowel movement and would not allow her to change the dressing; she stated he started yelling at her and using racial slurs. She stated he was very uncooperative and didn ' t want to stay in the facility. She did not know why the orders for the treatment did not get implemented.

On 01/27/2022 at 5:21 PM, an interview was conducted with the Wound Care Physician. He stated he did not see Resident #294 because he left against medical advice. He stated the order from the hospital discharge summary for the foam dressing would have been okay to leave on a wound for several days, changing when it was soiled. He did not have a concern about the foam dressing staying in place until the wound care nurse could assess the area on Monday.