

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER Windsor Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1306 South King Street Windsor, NC 27983	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37468</p> <p>Based on staff interviews, Wound Care Physician interview, and record review the facility failed to accurately document treatments on a resident's Treatment Administration Record (TAR) for 1 of 3 residents reviewed for pressure ulcer care. (Resident #1)</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility on [DATE]. Her active diagnoses included stage 4 pressure wound of the left heel.</p> <p>Review of Resident #1's wound care physician note dated 6/28/24 revealed the wound care physician documented Resident #1's treatment to her left heel was to be changed to sodium hypochlorite solution (dakins) apply once daily for 30 days: half strength; gauze roll (kerlix) apply once daily.</p> <p>Review of Resident #1's Treatment Administration Record (TAR) revealed from 7/1/24 through 7/12/24 there was no treatment documentation for Resident #1's left heel.</p> <p>During an interview on 8/5/24 at 11:29 AM Treatment Nurse #1 stated on 6/28/24 they had placed 1/2 dakins wet to dry on the wound per the wound care physician in the room at the time. She stated going forward she knew that the wound was to have 1/2 dakins wet to dry and that was what she was applying to the wound following 6/28/24. Upon review of the TAR, she stated from 7/1/24 through 7/12/24 there was no documentation of treatment to the left heel. She stated she was in the facility on 7/1/24 through 7/12/24 except for 7/6/24 and 7/7/24. She stated on the days she was here she knew she had placed 1/2 dakins wet to dry with an island boarder gauze on the left heel as had been discussed with the wound care physician on 6/28/24. On 7/6/24 and 7/7/24 Treatment Nurse #2 was the weekend treatment nurse and provided wound care, and she could not speak to if she provided treatment to the resident's left heel on those days. She stated she knew there was an order in place on 6/28/24 for the change in treatment to the wound to the heel and she did not know why it had disappeared from their system in July. She stated when he rewrote the order on 7/5/24 it would have replaced the one on 6/28/24 and been in the system and on the Treatment Administration Record. She stated this order had also disappeared from the system. She stated on 7/12/24 when the wound care physician rounded with her again, she noted that there was no order for the left heel wound and it had disappeared from the system. She stated due to this she reentered the order again as the wound care physician had not changed the order on 7/12/24 and that order had stayed in the system.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 8/5/24 at 2:56 PM Treatment Nurse #2 stated during the time from 7/1/24 through 7/12/24, she applied 1/2 dakins wet to dry dressing on Resident #1 as had been discussed with the wound care physician during his rounds on 6/28/24. She stated after the wound care physician finished his rounds each Friday, she and the other treatment nurse would ensure the treatments were correctly entered into their electronic records. She did not know or understand why that order was not showing up in the system as she knew she and Treatment Nurse #1 had placed the order in the record. She stated on 7/6/24 and 7/7/24 she provided dressing change to the left heel with 1/2 dakins wet to dry as had been discussed with the physician on 6/28/24. She stated she did not know why the order was not showing up in the system but knew that was the wound care she provided on those days.</p> <p>During an interview on 8/5/24 at 3:27 PM the Wound Care Physician stated he remembered Resident #1. He further stated on 6/28/24 he did change the wound care to Resident #1's heel to dakins half strength once daily wet to dry dressing with an island boarder gauze and discussed this with both treatment nurses. He stated based on the wound progression on his following visits on 7/5/24 and 7/12/24, it appeared the treatment nurses were applying this new treatment as he had ordered.</p> <p>During an interview on 8/5/24 at 8:02 AM the Director of Nursing stated treatment orders were to be placed on the Treatment Administration Record and the staff were to ensure they documented the treatments they provided accurately.</p>		