STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345116	A. Building B. Wing	12/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piedmont Hills Center for Nursing and Rehab	109 S Holden Rd Greensboro, NC 27407

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38129 Based on record review, staff, facility Nurse Practitioner, and wound care Nurse Practitioner interview, the facility failed to inform the nurse practitioners that wound care was not completed as ordered (Residents #28, and 32). The facility additionally failed to notify the urologist that Resident #19 ' s recommendations were not implemented. This was evident for 3 of 3 residents reviewed for notification of change. Findings included: 1. Resident #28 was admitted to the facility on [DATE] with the diagnosis of dementia. Resident #28 ' s admission Minimum Data Set (MDS) dated [DATE] documented he had clear speech, understood/understands and had severely impaired cognition. He required total dependence for all activities of daily living (ADL). He had two stage 2 pressure ulcers. Resident #28 ' s care plan dated 10/22/21 documented he had an ADL self-care performance deficit and potential for pressure ulcer. Resident #28 ' s physician order documented left heel paint DTI with skin prep each day started 10/28/21 and discontinued on 11/24/21. Resident #28 ' s physician order documented 11/11/21 right heel stage 2 pressure ulcer (PU) cleanse wound with cleanser, pat dry, apply silver alginate, and place a dry sterile dressing (DSD) each day. Resident #28 ' s physician order dated 11/24/21 documented left heel stage 2 PU cleanse wound with cleanser, pat dry, apply medihoney, and apply DSD each day. Resident #28 ' s October, November, and December 2021 treatment administration record (TAR) documentation had missing nursing initials for both right and left heel pressure ulcer care for dates: 10/28 - 31/21, 11/1 - 3/21, 11/12/21, 11/18/21, 11/19/21, 11/22/21, 11/28/21, 11/29/21 and 12/6/21. On 12/7/21 at 12:05 pm an interview was conducted with the Unit Supervisor (US) #1. US #1 stated that there was a nursing staffing shortage and wound care was not always completed as ordered. She stated the Director of Nursing was informed and she had not informed the nurse practitioner. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/8/21 at 11:00 am an interview was conducted with the facility Nurse Practitioner. He stated that he was not informed that residents ' wound care were not being completed as ordered. On 12/20/21 at 3:10 pm an interview was conducted with the Director of Nursing (DON). She stated when Resident #28 ' s pressure ulcers were identified as missed on admission the wound care Nurse Practitioner was informed. The missed wound care information was not provided to the facility or wound care nurse practitioner. 2. Resident #32 was admitted on [DATE] with the diagnosis of vascular dementia. Resident #32 ' s quarterly Minimum Data Set (MDS) dated [DATE] documented he had 1 stage 4 pressure ulcer and was dependent for all activities of daily living. Resident #32 ' s care plan dated 5/14/21 documented problem and interventions for pressure ulcer. Resident #32 had a physician order dated 8/3/21 left hip clean wound, apply hydrogel to wound bed, apply dry sterile dressing (DSD) each day. Resident #32 ' s August 2021 TAR was missing nursing initials wound care completed for dates 8/8/21, 8/11 - 14/21, 8/18 - 20/21, 8/25/21 and 8/27/21. Resident #32 ' s September 2021 TAR was missing nursing initials wound care completed for dates 9/6/21, 9/9/21, 9/16/21, 9/20/21, 9/27/21, and 9/30/31. Resident #32 had a physician order dated 9/16/21 clean the wound, pat dry, apply collagen to wound bed, followed by silver alginate and secure with DSD each day. Resident #32 ' s October 2021 TAR was missing nursing initials wound care completed for dates 10/1/21 10/4/21 10/7/21 10/14/21, 10/22/21. Order ended on 10/27/21 no initials for 10/27 - 30/21. Next order was 11/4/21. Resident #32 had a physician order dated 11/4/21 cleanse with dakin ' s solution, apply medihoney to wound bed, cover with silver alginate, and cover with DSD each day. Resident #32 ' s November 2021 TAR was missing nursing initials care completed for dates 11/5/21, 11/10/21, 11/11/21, 11/18/21, 11/19/21, 11/2821 and 11/29/21. Resident #32 ' s December 2021 TAR was missing nursing initials care completed for dates 12/1/21 and 12/6/21. On 12/7/21 at 12:05 pm an interview was conducted with the Unit Supervisor (US) #1. US #1 stated that there was a nursing staffing shortage and wound care was not always completed as ordered. She stated the Director of Nursing was informed and she had not informed the nurse practitioner. On 12/13/21 at 4:50 pm an interview was conducted with the wound care Nurse Practitioner. She stated that she was not informed that resident wound care was not completed as ordered. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/20/21 at 3:10 pm an interview was conducted with the Director of Nursing (DON). She stated when Resident #32 pressure ulcers were identified as missed on admission the wound care Nurse Practitioner was informed. The missed wound care information was not provided to the facility or wound care nurse practitioner. 41579 3. Resident #19 admitted to facility on 10/6/21 with diagnosis of urine retention. An admission Minimum Data Set (MDS) dated [DATE] indicated Resident #19 was cognitively intact and required limited assistance with 1-person physical assist with bed mobility, dependent assistance with 2-person physical assist with transfers, dependent assistance with 1-person physical assist with toilet use and bathing. Further review revealed resident had an indwelling urinary catheter. A review of report of consultation from Urology appointment dated 11/18/21 revealed diagnosis of urinary retention and recommendations to discontinue indwelling catheter for voiding trial, may replace if unable to void, and please notify urology office if unable to void. An interview was conducted on 12/5/21 at 1:46 PM with Resident #19 and it was stated there was an order for indwelling catheter to be discontinued after Urology appointment and have a voiding trial done. Resident #19 stated no one had approached them about discontinuing the indwelling catheter and having a voiding trial. On 12/08/21 at 1:37 PM an interview was conducted with the Director of Nursing (DON), and she stated Resident #19 had refused to have indwelling catheter discontinued after her urology appointment in November 2021 and that is why the voiding trial was not done. DON further stated a voiding trial would be conducted. On 12/9/21 at 1:24 PM an follow-up interview was conducted with Resident #19, and it was indicated they had not refused to have the indwelling catheter discontinued. Resident #19 stated they had only been asked on 12/8/21 about indwelling catheter being discontinued and the resident communicated to the Nurse they wanted to wait until the morning to have the voiding trial done because of an appointment (12/9/21) and the resident did not want to go to the appointment without it. Resident #19 stated no one had approached them about discontinuing the catheter prior to 12/8/21 or when they returned from the Urologist in November. Resident #19 stated it had not been done and no one had talked about it or the voiding trial, even after it was brought to the facility staff attention. On 12/9/21 at 3:23 PM an interview was conducted with the Administrator, and it was indicated her expectation was for staff to follow orders as ordered by the physician.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28265 Based on observations, record review, family, resident, and staff interviews the facility failed to maintain an odor free living environment for rooms 205, 213, 218, 223, 224, 226 and in the facility common areas on the 200 hall. The facility additionally failed to maintain clean furniture, bathrooms floors and toilets in rooms 205, 220, 222 and 223. This was evident for 9 of 34 rooms observed on the 200 hall. Findings included: 1. Observations of the 200 unit revealed the following: a. On 12/05/2021 at 11:30am the 200 hall had a foul urine sewage odor in the common areas b. On 12/6/21 at 1:30 pm rooms 201, 205, 212, 213, 218, 223, 224 and 226 and the common areas (this nursing station, dining room and bathroom), had a foul sewage odor. c. On 12/7/21 at 9:45 am the 200 hall had a foul urine sewage odor in the common areas (nursing station, both hallway, and dining room). d. On 12/7/21 at 9:48 room [ROOM NUMBER] had a foul urine and sewage odor. e. On 12/7/21 at 9:56 am room [ROOM NUMBER] had a sewage odor. f. On 12/7/21 at 10:00 am room [ROOM NUMBER] had a sewage odor. An interview with the resident who resided in room [ROOM NUMBER] revealed the odor on this hall had been present for years and the resident's are used to the odor. The resident stated the administrator had been working on this for months and when it rained the odor became worse. g. On 12/7/21 at 10:23 room [ROOM NUMBER] was observed with a foul urine and sewage odor in the resident's room and bathroom. An interview with the resident who resided in room [ROOM NUMBER] revealed the odor was sewage and it had been like that for months. h. On 12/7/21 at 1:00pm room [ROOM NUMBER] had a foul sewage odor; there were no residents in room [ROOM NUMBER]. I. On 12/8/21 at 5:30 am a strong urine and sewage odor was present in the common areas (nursing station, dining room and bathroom) of the 200 hall. j. On 12/8/21 at 10:23 am room [ROOM NUMBER] had a foul urine odor in the resident's room and bathroom. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	k. On 12/9/21 at 1:00 pm the common areas (nursing station and dining room) on the 200 hall had a strong, foul urine and sewage odor. A Family Member (FM) Interview for resident that was residing in room [ROOM NUMBER] was conducted on 12/07/2021 at 3:00 pm. The FM revealed during visits with her brother she noted a foul urine and sewage odor in the facility. The FM indicated she had spoken with the Nurses and Administrator about the odor, and it was reported that because the building was old when it rained the backup from the sewage caused the odor in the building. The FM indicated the Administrator told her they were working on this concern. The FM stated that was about 4 months ago, and the odor was still in the facility during her last visit. During interview with Nursing Assistant (NA#8) on 12/08/2021 at 6:00am, she indicated she had been working at the facility for about 3 months and did not smell the sewage odor but sometime there was a foul odor when the resident's received early morning care. During an interview with Nurse #5 on 12/09/2021 at 4:00pm, Nurse #5 indicated she had worked at the facility for several years and the facility has had an odor. She added the odor was not from the care of the residents but because of the facility being old. Nurse #5 indicated it was an old sewage smell. During an interview with Nursing Assistant #11 on 12/9/21 at 4:15 pm who worked on the 200 hall indicated the facility was old, but no odor was present on the 100 hall just the 200 hall had the odor. She indicated it was just a funny smell. During an interview with the Maintenance Director on 12/09/2021 at 4:30pm, he indicated he was aware of the odor in the facility, and he had conducted a 100% audit of all the resident rooms and if any issues were identified housekeeping and plumbing would be completed. During an interview with Administrator on 12/10/2021 at 10:30 am, she indicated had been identified that the plumbing had caused an offensive odor in the residents' rooms and care areas. She stated the Maintenance Director conducted a 100% audit of all resident rooms, bathrooms, shower rooms and common areas. Any areas that had been identified as having an issue would be evaluated by the Maintenance Director and corrective actions would be put into place. She stated nothing about the date of corrective action being completed. If the area needs to be cleaned housekeeping would perform the task, if the odor was identified as a plumbing issue, the Maintenance Director would be responsible for taking care of the problem. Administrator indicated she would contact a vendor for issues with the plumbing that the Maintenance Director was unable to fix. The Administrator indicated staff would be educated on odor control and reporting odors in the facility. She also indicated that the medical director was informed of the odor issues and the issues with the plumbing. The Administrator stated a vendor would be called to evaluate the situation and see what needed to be done to help control the odors in the facility. 38129 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 12/6/21 at 10:40 am an observation was done of room [ROOM NUMBER]. The bed frame and rails were noted to have brown soil with food crumbs. The back of the air mattress controller box had visible dust and crumbs. The resident ' s wheelchair had food crumbs accumulated on the frame and on each side of the seat. The bed controller had brown soil. Concurrent interview with the resident: she stated that she noticed the dust and food crumbs. Housekeeping only cleaned the floor, bathroom, bedside table, and doorknobs. She stated her bed rails, the back of the mattress box, and wheelchair had not been cleaned in a long time. On 12/6/21 at 11:10 am an observation was done of rooms #205, 222, and 223. Both bathrooms appeared to have brown soil on the floor and toilet. room [ROOM NUMBER] had what appeared to be dark urine in the toilet with strong odor and was not flushed. There were numerous brown paper towels on the floor around the toilet and empty urinals. room [ROOM NUMBER] had brown paper towels on the toilet seat covered in stool. room [ROOM NUMBER] bed A frame and bed controller had visible brown soil. room [ROOM NUMBER] bed A had visible brown soil on the bed frame, wheelchair, and bed controller. On 12/6/21 at 3:55 pm an observation was done of room #s 205, 220, 222, and 223. The rooms remained in the same condition as was observed at 11:10 am this morning. On 12/9/21 at 12:10 pm an interview was conducted with Housekeeper #1. She stated that the areas cleaned daily in the resident's room were the floors, bathroom, doorknobs, and tray table. Any other surfaces were cleaned when visibly soiled. She stated she had not routinely cleaned the bedside rails or frame, call light, bed and TV remote, or the air mattress pressure device (if one was present). She stated that she had not cleaned the resident's wheelchairs, that was the responsibility of the housekeeping floor tech. On 12/9/21 at 12:20 pm an interview was conducted with the housekeeping supervisor (HS). HS stated she started a week ago. There were 2 housekeepers scheduled for all days/shift. HS stated when she was hired there was only 1 housekeeper employed and the other 2 housekeepers were hired within the past week. The two new housekeepers needed training. She stated the high touch areas in the resident's room were bathroom, doorknob, bedside table, and dresser. She had not directed the housekeeper to clean the side rails, call light, and TV and bed remotes. The wheelchairs would be scheduled for cleaning by the housekeeping floor tech and wheelchair handles and arm rests were not planned for daily cleaning. The HS stated she was not aware that the bed control and TV remotes, bed rails, wheelchairs, and air mattress pressure device had visible soiling. The HS stated there would a plan to deep clean the rooms which included all the other surfaces not included in daily cleaning.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38129 Based on record review, staff interview, the facility failed to develop a care plan for an actual pressure ulcer (Resident #28) for 1 of 24 residents reviewed for care plan. Findings included: Resident #28 was admitted to the facility on [DATE] with the diagnosis of dementia. Nursing admission note dated 10/14/21 documented Resident #28 had a blister on his right foot (heel) and a skin tear on his right buttock. There was not documentation that the left heel was assessed. Resident #28 ' s care plan dated 10/22/21 documented he had an ADL self-care performance deficit and potential for pressure ulcer. Resident #28 ' s admission Minimum Data Set (MDS) dated [DATE] documented he had clear speech, understood/understands and had severely impaired cognition. He required total dependence for all activities of daily living (ADL). He had two stage 2 pressure ulcers. On 12/20/21 at 2:30 pm an interview was conducted with the MDS Coordinator. She stated that Resident #28 ' s heel pressure ulcers were missed on admission and a care plan for actual pressure ulcers was not completed. On 12/20/21 at 3:10 pm an interview was conducted with the Director of Nursing (DON). She stated Resident #28 had blisters on his heels on admission that were missed, and a care plan was not done.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38129 Based on record review, observation and interviews of the staff and nurse practitioner, the facility failed to consistently complete wound care as ordered (Residents #323 and 19) for 2 of 2 sampled residents. Findings included: 1. Resident #323 was admitted to the facility on [DATE] with the diagnoses of heart failure and bullous pemphigus (skin disease). Resident #323 ' s physician progress note date 7/1/21 documented her right foot turned necrotic and family declined surgery (amputation) and decided on comfort measures. Resident #323 ' s physician order dated 7/1/21 documented xeroform gauze to the skin tears cover with dry sterile dressing every other day to the right foot, skin prep and dry sterile dressing each day to left lateral foot, and cleanse with saline, triple antibiotic ointment, wrap with kerlix each day to left leg. Resident #323 ' s treatment administration record (TAR) for July 2021 had no initials for wound care documented for left leg wound care missing nursing initials for dates 7/5/21, 7/26/21, 7/29/21, and 7/30/21. Left lateral leg each day order started 7/15/21 was missing nursing initials for dates 7/26/21, 7/29/21, and 7/30/21. Right foot every other day order was missing nursing initials for dates 7/5/21 and 7/29/21. Resident #323 ' s significant change Minimum Data Set (MDS) dated [DATE] documented decline of the right foot from peripheral arterial disease resulting in gangrene. Resident #323 ' s August 2021 TAR no initials for wound care documented for left medial leg for dates 8/6/21, 8/8/21, 8/11-14/21, 8/18 - 20/21, and 8/25 - 27/21. Left leg was missing nursing initials for dates 8/6/21, 8/8/21, 8/11-14/21, 8/18 - 20/21, and 8/25 - 27/21. Right foot was missing nursing initials for dates 8/6/21, 8/8/21, 8/12/21, 8/14/21, 8/18/21, 8/20/21, and 8/26/21. Resident #323 ' s September 2021 TAR no initials for wound care documented to left medial leg was missing nursing initials for dates 9/6/21, 9/9/21, 9/16/21, 9/20/21, 9/24/21, 9/27/21, and 9/30/21. Left leg was missing nursing initials for dates 9/6/21, 9/9/21, 9/16/21, 9/20/21, 9/24/21, 9/2721, and 9/30/21. Right foot was missing nursing initials for dates 9/921, 9/24/21, 9/27/21, and 9/30/21. Resident #323 ' s quarterly MDS dated [DATE] documented the resident had clear speech, understood/understands. Her cognition was moderately impaired. The active diagnoses were peripheral arterial disease and bullous pemphigus (skin disorder). Care plan updated 11/24/21 for right foot decline documented I have impaired skin integrity of the left lower leg with open areas noted to left leg, right foot and back. Right foot is necrotic. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/6/21 at 10:10 am an interview was conducted with the wound care nurse (WCN). The WCN stated that she was responsible for all resident wounds with dressings except minor skin tears. The WCN stated that the Director of Nursing (DON) was responsible to inform nursing staff to complete wound care when the WCN was not available. The WCN stated that she had noticed on a couple of occasions the resident ' s wound dressing date was not the day before, but older (day or two). The WCN stated she informed the DON of the missed dressing changes. On 12/7/21 at 12:05 pm an interview was conducted with the Unit Supervisor (US) #1. The US #1 stated that when the wound care nurse was pulled to a nursing assignment, she and the staff were not always informed until later in the day (when residents were up in their wheelchair and declined care) or not at all and wound care was not completed. She stated there was a break-down in communication. US #1 also stated that when a nurse had to cover 1 unit/2 halls with a medication aide, there was not enough time to complete wound care when the wound care nurse was not available. US #1 stated that there was a nurse staffing shortage and was aware that wound care was not always completed. On 12/8/21 at 11:00 am an interview was conducted with the facility Nurse Practitioner. He stated that he was not aware that residents ' wound care was not being completed as ordered. On 12/20/21 at 3:10 pm an interview was conducted with the Director of Nursing (DON). The DON was informed by staff that wound care was not always completed due to insufficient staffing. 41579 2. Resident # 19 was admitted to the facility 10/6/21. Cumulative diagnosis included complete amputation at level of below knee and ankle. An admission Minimum Data Set (MDS) dated [DATE] indicated Resident # 19 was cognitively intact and required limited assistance with 1-person physical assist with bed mobility, dependent assistance with 2-person physical assist with transfers, dependent assistance with 1-person physical assist with toilet use, bathing. Skin conditions included a surgical wound that was present on admission. Resident #19 ' s physicians orders were reviewed. On 10/14/21, there were physician ' s orders to 1. Clean right thigh donor site with wound cleaner, pat dry, apply xeroform sterile gauze followed by dry dressing daily, 2. Paint right below knee amputation (RBKA) surgical site with skin prep daily, 3. Clean left leg graft site with wound cleaner, pat dry, apply Xeroform Sterile Gauze to open areas, secure with dry dressings daily. A care plan dated 10/18/21 revealed Resident #19 had actual impairment to skin integrity of the right knee related to surgical wound. Interventions included maintain or develop clean and intact skin A review of the treatment record (TAR) for the months of October, November and December 2021 revealed missing nursing initials for treatment to right thigh donor site, for dates: 10/14/21, 10/18/21, 10/22/21, 10/28/21, 10/30/21, 10/31/21, 11/2/21, 11/3/21, 11/5/21, 11/8/21, 11/10/21, 11/11/21, 11/18/21, 11/19/21, 11/23/21, 11/26/21, 11/28/21, 11/29/21, 11/30/21, 12/1/21, 12/6/21, to RBKA surgical site for dates: 10/14/21, 10/18/21, 10/28,21, 10/30/21, 10/31/21, 11/2/21, 11/3/21, 11/5/21, 11/8/21, 11/10/21, and to left leg graft site for dates: 10/14/21, 10/18/21, 10/22/21, 10/28/21, 10/30/21, 10/31/21, 11/2/21, 11/3/21, 11/5/21, 11/8/21, 11/10/21, 11/11/21, 11/18/21, 11/19/21, 11/23/21, 11/24/21, 12,1/21, 12/6/21. RBKA healed and ordered discontinued on 11/11/2021. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/05/21 at 1:55 PM Resident #19 indicated wound care was not being treated consistently. Resident #19 indicated wounds were getting treated daily then approximately 2 1/2 weeks ago wound care stopped. Resident #19 stated it was reported to Nursing staff wound care was not being done. An observation of wound care nurse (WCN) perform wound care was conducted on 12/8/21 at 6:51 AM. WCN performed wound care to right thigh donor site and left leg graft site. WCN cleaned both sites with wound cleanser, dried with dry gauze, applied skin prep as ordered. Right thigh donor site left open to air and left leg graft site a zinc infused compression sock applied to left leg as ordered. No concerns were identified with wound care provided. Observation of right thigh donor site with healing skin and left leg graft site approximately quarter sized with bloody drainage from site. On 12/6/21 at 10:10 am an interview was conducted with the wound care nurse (WCN). The WCN stated she had started her position in July 2021 and was responsible for all resident wounds with dressings except minor skin tears. The WCN stated she was required to carry a phone and be responsible to float into a nurse assignment rotating with 2 other staff when there was not enough staff 7 days a week. The WCN stated when she worked on the weekend, she would have weekday(s) off (which depended on whether she worked both weekend days). The WCN stated when she was not available to provide wound care, the assigned nurse was responsible to provide wound care for that day. The WCN stated that the DON was responsible to inform nursing staff to complete wound care when the WCN was not available. The WCN indicated she had not audited the resident TAR for completed wound care. The WCN stated that she had noticed on a couple of occasions the resident ' s wound dressing date was not the day before, but older (day or two). The WCN stated she informed the DON of the missed dressing changes. On 12/14/17 at 3:25 PM, the Director of Nursing was interviewed and stated she expected staff to follow physician orders for wound care.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piedmont Hills Center for Nursing and Rehab	109 S Holden Rd Greensboro, NC 27407

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38129 Based on record review, observation and interviews of the staff, nurse practitioner, and family member, the facility failed to assess and provide wound care for both heel pressure ulcers upon admission which resulted in deep tissue injury and open wounds (Resident #28) and failed to consistently complete pressure ulcer care as ordered (Residents #28, 32 and 19) for 3 of 3 sampled residents. Findings included: 1. Resident #28 ' s FL2 (cognition and body assessment form) from the hospital dated 10/4/21 provided nursing notes of resident's skin assessment which documented right heel slightly blistered area of red 5 cm (centimeters) by 4 cm and left heel slightly blistered faint purple 3 x 6 cm. Resident #28 was admitted to the facility on [DATE] with diagnosis of dementia. Nursing admission note dated 10/14/21 documented Resident #28 had a blister on his right foot (heel) and a skin tear on his right buttock. There was no documentation that the left heel was assessed. There were no physician orders for pressure ulcer care and/or pressure relieving interventions implemented on admission documented. Resident #28 ' s admission Minimum Data Set (MDS) dated [DATE] documented he had clear speech, understood/understands and had severely impaired cognition. He required total dependence for all activities of daily living (ADL). He had two stage 2 pressure ulcers. Resident #28 ' s care plan dated 10/22/21 documented he had an ADL self-care performance deficit and potential for pressure ulcer. Resident #28 ' s nurses' note dated 10/25/21 documented right and left heels are dark purple, non-blanchable, boggy, with uneven edges. There was a small open area to the sacrum. Resident #28 ' s progress note dated 10/25/2021 resident representative stated resident had bilateral breakdown (blister) to heels and sacrum (open area) while in hospital (10/14/21). Note was written by the Director of Nursing. Resident #28 ' s progress note dated 10/26/2021 for skin/wound: Foam dressing applied to bilateral heels, old sacral wound and area was cleaned, and dressing applied for added protection. Resident representative was informed regarding wounds and the wound care specialist will evaluate tomorrow. Note was written by the Treatment Nurse. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/20/21 at 3:10 pm an interview was conducted with the Director of Nursing (DON). She stated Resident #28 had blisters on his heels on admission. Only the right heel was documented. FL2 documented by the hospital revealed the resident had slight blister to both heels. The DON stated that there was no documentation or orders for care or pressure relief boots for the heels from admission 10/14/21 until 10/25/21 when the wound care Nurse Practitioner was notified, assessed the resident, and provided orders. The resident ' s blisters had opened and were now stage 2. The DON stated that a blister was considered a stage 2 pressure ulcer. On 10/25/21 the heels were now open, and an order was obtained for treatment. The wound care Nurse Practitioner assessed the heels, and they were documented as deep tissue injury (DTI). Resident #28 ' s physician order documented right heel paint DTI with skin prep each day started 10/28/21 and discontinued on 11/11/21. Resident #28 ' s physician order documented left heel paint DTI with skin prep each day started 10/28/21 and discontinued on 11/24/21. Resident #28 ' s physician order documented 11/11/21 right heel stage 2 pressure ulcer (PU) cleanse wound with cleanser, pat dry, apply silver alginate, and place a dry sterile dressing (DSD) each day. Resident #28 ' s physician order documented left heel stage 2 PU cleanse wound with cleanser, pat dry, apply medihoney, and apply DSD each day. Resident #28 ' s October, November, and December 2021 treatment administration record (TAR) documentation had missing nursing initials for both right and left heel pressure ulcer care for dates: 10/28 - 31/21, 11/1 - 3/21, 11/12/21, 11/18/21, 11/19/21, 11/22/21, 11/28/21, 11/29/21 and 12/6/21. On 10/27/2021 Resident #28 ' s progress note dated 10/27/21 by Nurse Practitioner wound care specialist documented initial assessment of wounds. Resident had the following wounds: Left heel DTI measures 3.6 x 6 centimeter (cm); Right heel DTI measures 5 x 6.5 cm; Right lateral foot wound measures 3 x 1.2 cm (new). Treatment recommendation was given to paint wounds with skin prep daily followed by dry dressing. Sacral area was resolved with noted scarred tissue. On 12/13/21 at 10:30 am an interview was conducted with Resident #28 ' s resident representative/family member. She stated that the resident had acquired a small blister to both of his heels while he was in the hospital. She stated the resident had no dressing on his heels or protection for pressure at the facility. She observed that the blisters opened and got larger and were draining with no dressing in place. She stated that staff placed shoes on the resident ' s feet with open, heel wounds and no dressing. There was drainage in his shoes. She stated that she informed the Administrator that the heels were not being taken care of and he had no protection to the heels. She stated that the Administrator had the staff place a dressing and boots to prevent pressure. She stated that the staff had not changed the resident ' s dressing. The dressing had an old date (not the day before) and was falling off. She stated after informing the Administrator, the problems got better about 3 weeks after admission. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/7/21 at 11:30 am an interview was conducted with the facility Nurse Practitioner. He stated that if a pressure ulcer was not dressed and provided pressure relief, the fragile tissue would become damaged and increased in size. The ulcer also had the possibility to become infected. He stated he was not aware that Resident #28 ' s pressure ulcer was missed on admission. The facility had used agency nurse staff, they were not familiar with the resident, and could not provide him a resident update. On 12/7/21 at 12:05 pm an interview was conducted with the Unit Supervisor (US) #1. The US #1 stated that she, the wound care nurse and Infection Preventionist were required to carry a phone for on-call nursing assignment. When there was a nurse call out that could not be filled, one of the three staff were expected to take turns to cover the assignment. The US #1 stated that when the wound care nurse was pulled to a nursing assignment, she and the staff were not always informed until later in the day (when residents were up in their wheelchair and decline care) or not at all and wound care was not completed. She stated there was a break-down in communication. US #1 also stated that when a nurse had to cover 1 unit/2 halls with a medication aide, there was not enough time to complete wound care when the wound care nurse was not available. US #1 stated that there was a staffing shortage. Resident #28 ' s risk meeting note dated 11/18/2021 documented resident reviewed for healing pressure wounds to both feet. Resident was seen by the wound care Nurse Practitioner on 11/17/21 for assessment and treatment recommendation. The Nurse Practitioner documented the resident ' s right lateral foot DTI had resolved. Resident ' s left heel DTI measures 3 x 4.8 cm. Treatment plan for skin prep to wound daily followed by dry dressing. Resident ' s right heel stage 2 pressure wound measures 3 x 2.6 x 0.1cm with 100% granulation and moderate serosanguinous exudate. Treatment continues with silver alginate to wound bed daily secured with dry dressing. Resident #28 ' s skin/wound note dated 12/2/21 documented the resident was seen by the wound care Nurse Practitioner for assessment and treatment recommendation of wounds to both feet. The Nurse Practitioner ' s assessment documented DTI to left heel is now a stage 2 pressure injury. New treatment order for medihoney to wound bed followed by dry dressing daily. Stage 2 pressure wound to right heel will continue with daily treatment of silver alginate and dry dressing daily. The left heel measured 3 x 4 x 0.1 cm and the right heel measured 2.3 x 1.5 x 0.1cm. Resident #28 ' s skin/wound note dated 12/8/2021 documented the resident was seen by the wound care Nurse Practitioner today for assessment and treatment recommendations. The resident has stage 2 pressure injury to both heels. The left heel wound measured 2 x 1.6 x 0.1cm with 100% granulation tissue and moderate serosanguinous exudate. Treatment continues as, Medihoney to wound bed followed by dry dressing daily. The right heel wound measured 2 x 1.3 x 0.1cm with 100% granulation tissue and moderate serosanguinous Exudate. Treatment continued with medihoney to wound bed followed by silver alginate, secured with dry dressing daily. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/6/21 at 10:10 am an interview was conducted with the wound care nurse (WCN). The WCN stated that she had started her position in July 2021 and was responsible for all resident wounds with dressings except minor skin tears. The WCN stated she was required to carry a phone and be responsible to float into a nurse assignment rotating with 2 other staff when there was not enough staff 7 days a week. The WCN stated when she worked on the weekend, she would have weekday(s) off (which depended on whether she worked both weekend days). The WCN stated when she was not available to provide wound care, the assigned nurse was responsible to provide wound care for that day. The WCN stated that the DON was responsible to inform nursing staff to complete wound care when the WCN was not available. The WCN had not audited the resident TAR for completed wound care. The WCN stated that she had noticed on a couple of occasions the resident ' s wound dressing date was not the day before, but older (day or two). The WCN stated she informed the DON of the missed dressing changes. On 12/7/21 at 9:35 am an interview was attempted with the wound care Nurse Practitioner. A detailed message was left for return call. On 12/8/21 at 10:00 am an observation was attempted for Resident #28 ' s pressure ulcer of the heels. The resident declined. On 12/13/21 at 4:50 pm an interview was conducted with the wound care Nurse Practitioner. She stated that she was not aware that wound care was not completed as ordered. She stated that failing to provide wound care as ordered could cause a set-back for the wound. When exudate (wound drainage) sits on the wound and surrounding skin there can be tissue breakdown and bacterial growth (infection). 2. Resident #32 was admitted on [DATE] with the diagnosis of vascular dementia. Resident #32 ' s quarterly Minimum Data Set (MDS) dated [DATE] documented he had 1 stage 4 pressure ulcer and was dependent for all activities of daily living. Resident #32 ' s care plan dated 5/14/21 documented problem and interventions for pressure ulcer. Resident #32 ' s wound care note dated 8/17/21 measured the stage 4 left hip at (length x width x depth) 0.3 x 1.3 x 0.1 centimeters (cm). Resident #32 ' s wound care note dated 8/25/21 measured the stage 4 left hip at 0.3 x 2 x 0.1 cm. Resident #32 had a physician order dated 8/3/21 left hip clean wound, apply hydrogel to wound bed, apply dry sterile dressing (DSD) each day. Resident #32 ' s August 2021 TAR was missing nursing initials wound care completed for dates 8/8/21, 8/11 - 14/21, 8/18 - 20/21, 8/25/21 and 8/27/21. Resident #32 ' s wound care note dated 9/15/21 measured the stage 4 left hip at 1.6 x 3.5 x 0.2 cm. Surrounding tissue had maceration (skin breakdown from moisture). Resident #32 ' s progress note dated 9/22/21 measured the stage 4 left hip at 1.2 x 3 x 0.2 cm Resident #32 ' s September 2021 TAR was missing nursing initials wound care completed for dates 9/6/21, 9/9/21, 9/16/21, 9/20/21, 9/27/21, and 9/30/31. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #32 had a physician order dated 9/16/21 clean the wound, pat dry, apply collagen to wound bed, followed by silver alginate and secure with DSD each day. Resident #32 ' s progress note dated 10/20/21 measured the stage 4 left hip at 0.7 x 2 x 0.1cm. Resident #32 ' s October 2021 TAR was missing nursing initials wound care completed for dates 10/1/21 10/4/21 10/7/21 10/14/21, 10/22/21. Order ended on 10/27/21 no initials for 10/27 - 30/21. Next order was 11/4/21. Resident #32 had a physician order dated 11/4/21 cleanse with dakin ' s solution, apply medihoney to wound bed, cover with silver alginate, and cover with DSD each day. Resident #32 ' s progress note dated 11/4/21 measured the stage 4 left hip at 1.2 x 2.5 x 0.2 cm. The wound had moderate drainage. Resident #32 ' s progress note dated 11/18/21 measured the stage 4 left hip at 0.8 x 2 x 0.2 cm. The wound had moderate drainage. Resident #32 ' s November 2021 TAR was missing nursing initials care completed for dates 11/5/21, 11/10/21, 11/11/21, 11/18/21, 11/19/21, 11/2821 and 11/29/21. Resident #32 ' s December 2021 TAR was missing nursing initials care completed for dates 12/1/21 and 12/6/21. On 12/7/21 1:55 pm an interview was conducted with the wound treatment nurse (TN). She stated she started at the facility July 2021 and was responsible for all wounds (except skin tears) Monday through Friday. Nursing staff assigned to a resident with a wound was responsible for care on the weekends and when the TN was absent. She stated that she was responsible to be on call for licensed nursing call outs. She carried a phone and was called 7 days a week, rotating with other staff. The TN stated when she was floated to a nursing staff position, the nursing staff who had residents with wounds were responsible to provide wound care on their shift. The TN stated if she was required to cover a nursing shift on the weekend, she would have day(s) off during the week. The TN noted that on some weekends there were no initials that wound care was completed. The TN stated that she signed the TAR for all the days that she completed wound care and did not know why there were multiple blanks for the initial block. TN stated that she never looked back at the TAR to see if wound care was documented as completed. TN had received no communication that care was not completed. TN stated that the DON and Unit Manager communicated to nursing staff when the TN was not available to complete the resident wound care on their assignment. TN stated that she had noted a couple of times in November the date on the resident's wound dressing was not dated the day before. She assumed the care had not been completed and informed the DON. TN could not remember which days the wound dressing had an older date. TN stated she rounded each Wednesday with the wound care Nurse Practitioner. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/7/21 at 3:46 pm an interview was conducted with the Administrator. She stated that the DON, wound treatment nurse, staff development coordinator, and unit manager all were on call/rotate to cover licensed nursing call outs. The four staff rotate. She stated she knew that the treatment nurse carried an on-call phone and was required to be pulled to a nursing assignment any day of the week. She stated that she knew the treatment nurse had weekdays off when required to work on the weekend. The Administrator was informed that since July 2021 to December 2021 there were multiple omissions of nursing signature for wound care treatment not completed on the TAR and that the treatment nurse was interviewed and stated she signed for all the wound care she completed. The Administrator stated that a failure to clean and change the dressing for a wound would cause infection and decline. 12/8/21 at 10:40 am an observation was done of the resident's sacral decubitus care by the treatment nurse. She followed the order and infection control. There were no concerns observed. On 12/8/21 at 11:00 am an interview was conducted with the facility Nurse Practitioner. He stated that he was not aware that residents ' wound care was not being completed as ordered. Resident #32 now had a new open area abrasion to his inner thigh due to contracture pressure. He stated that there has been a problem with staffing. There was not enough staff and contract staff do not know the residents. He stated when he would ask a contract nurse for the history of a resident, the nurse would state I don't know, I have only been here 1 day. He stated that if a resident had not received wound care on average 7 days per month since August 2021 there would be infection and/or wound decline. On 12/8/21 at 11:10 am an interview was conducted with Unit Supervisor #1. The US was aware that the wound care was not completed as ordered due to staffing shortage and staff getting behind in their work then unable to complete wound care. She stated the treatment nurse (TN) was floated to an assignment and staffing assigned were responsible to perform wound care for that day. Staff was not always informed when the TN was not available and wound care needed to be completed by staff assigned. There was a communication problem/breakdown. She stated that on the second-floor unit when there were 2 medication aides and 1 nurse assigned, there were too many residents that required wound care to be completed by 1 nurse on day shift. She stated nurses work 12 hours and the second shift had not completed the wound care and she did not know why. She stated that later in the day she would inform the Director of Nursing (DON) that wound care was not completed when the TN was not available. The DON was not informed of each occurrence. She stated she was not auditing the resident TAR for missed care and had not known how many occurrences per month. The problem had been going on for a couple of months. 41579 3. Resident # 19 was admitted to the facility 10/6/21. Cumulative diagnosis included a stage 3 pressure ulcer to the occipital (back of the head). An admission Minimum Data Set (MDS) dated [DATE] indicated Resident # 19 was cognitively intact and required limited assistance with 1-person physical assist with bed mobility, dependent assistance with 2-person physical assist with transfers, dependent assistance with 1-person physical assist with toilet use, bathing. Skin conditions included a stage 3 pressure ulcer that was present on admission. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #19 ' s physicians orders were reviewed. On 10/14/21, there was a physician ' s order to clean stage 3 occipital head wound with wound cleanser, pat dry, apply Medi honey to open area followed by a dry dressing daily for wound treatment. A care plan dated 10/18/21 revealed Resident #19 had potential for pressure ulcer development related to immobility. Interventions included administer treatments as ordered and monitor for effectiveness. A review of the treatment record (TAR) for the months of October, November and December 2021 revealed missing nursing initials for treatment to occipital head wound for dates as follows: 10/14/21, 10/18/21, 10/22/21, 10/27/21, 10/28/21, 10/30/21, 10/31/21, 11/1/21, 11/2/21, 11/5/21, 11/8/21, 11/10/21, 11/11/21, 11/18/21, 11/19/21, 11/23/21, 11/26/21, 11/28/21, 11/29/21, 11/30/21, 12/1/21, and 12/6/21. On 12/05/21 at 1:55 PM Resident #19 indicated wound care was not being treated consistently. Resident #19 indicated wound was getting treated daily then approximately 2/12 weeks ago wound care stopped. Resident #19 stated it was reported to Nursing staff wound care was not being done. An observation of wound care nurse (WCN) perform wound care was conducted on 12/8/21 at 6:51 AM. WCN performed wound care to occipital wound. WCN removed old bandage with date of 12/7/21 with small amount of tan drainage to dressing. WCN cleaned wound with wound cleanser, dried with dry gauze, applied skin prep, and placed a dry dressing to area. No concerns were identified with wound care provided. Observation of occipital wound revealed an approximately nickel sized superficial wound without drainage. On 12/6/21 at 10:10 am an interview was conducted with the wound care nurse (WCN). The WCN stated she had started her position in July 2021 and was responsible for all resident wounds with dressings except minor skin tears. The WCN stated she was required to carry a phone and be responsible to float into a nurse assignment rotating with 2 other staff when there was not enough staff 7 days a week. The WCN stated when she worked on the weekend, she would have weekday(s) off (which depended on whether she worked both weekend days). The WCN stated when she was not available to provide wound care, the assigned nurse was responsible to provide wound care for that day. The WCN stated that the DON was responsible to inform nursing staff to complete wound care when the WCN was not available. The WCN indicated she had not audited the resident TAR for completed wound care. The WCN stated that she had noticed on a couple of occasions the resident ' s wound dressing date was not the day before, but older (day or two). The WCN stated she informed the DON of the missed dressing changes. On 12/14/17 at 3:25 PM, the Director of Nursing was interviewed and stated she expected staff to follow physician orders for pressure ulcer care.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41579 Based on record review, observations, resident, and staff interviews the facility failed to obtain a physician order for the use of an indwelling urinary catheter and failed to follow a urologist order for a voiding trial for one (Resident #19) of one resident reviewed for indwelling urinary catheter use. Findings included: Resident #19 admitted to facility on 10/6/21 with diagnosis of urine retention. A review of a nursing progress note dated 10/6/21 read in part Resident #19 admitted to facility with an indwelling catheter due to urine retention. Resident #19 ' s physicians orders were reviewed and no order for an indwelling catheter was found. An admission Minimum Data Set (MDS) dated [DATE] indicated Resident #19 was cognitively intact and required limited assistance with 1-person physical assist with bed mobility, dependent assistance with 2-person physical assist with transfers, dependent assistance with 1-person physical assist with toilet use and bathing. Further review revealed resident had an indwelling urinary catheter. A review of report of consultation from Urology appointment dated 11/18/21 revealed diagnosis of urinary retention and recommendations to discontinue indwelling urinary catheter for voiding trial, may replace if unable to void, and please notify urology office if unable to void. Further review of the of the medical record revealed no documentation of the voiding trial. An interview was conducted on 12/5/21 at 1:46 PM with Resident #19 and it was stated there was an order for indwelling catheter to be discontinued after Urology appointment. Resident #19 stated no one had approached them about discontinuing the indwelling urinary catheter. On 12/08/21 at 7:13 AM an interview was conducted with the Wound Nurse, and she verified Resident #19 had an indwelling catheter. She indicated Resident #19 was admitted to facility with the indwelling urinary catheter and she did not know why the resident did not have an order; however, stated there should be an order for the indwelling urinary catheter. On 12/08/21 at 7:17 AM an interview was conducted with the Director of Nursing (DON), and she stated Resident #19 should have had an order for the indwelling urinary catheter and she would see what happened. A follow up interview was conducted with the DON on 12/08/21 at 1:37 PM and she stated Resident #19 had refused to have indwelling urinary catheter discontinued after her urology appointment in November 2021. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/9/21 at 1:24 PM an follow-up interview was conducted with Resident #19, and it was indicated they had not refused to have the indwelling urinary catheter discontinued. Resident #19 stated they had only been asked on 12/8/21 about the indwelling urinary catheter being discontinued and the resident communicated to the Nurse they wanted to wait until the morning to have the voiding trial done because of an appointment (12/9/21) and the resident did not want to go to the appointment without it. Resident #19 stated no one had approached them about discontinuing the indwelling urinary catheter prior to 12/8/21 or when they returned from the Urologist in November. Resident #19 stated it had not been done and no one had talked about it, even after it was brought to the facility staff attention. On 12/9/21 at 3:23 PM an interview was conducted with the Administrator, and she stated the resident should have had an order for the indwelling urinary catheter on admission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345116	A. Building B. Wing	12/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piedmont Hills Center for Nursing and Rehab	109 S Holden Rd Greensboro, NC 27407

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)
F 0725 Level of Harm - Actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 38129 Based on record review, observation and interviews of staff, nurse practitioner and family member, the facility failed have sufficient nursing staff to provide wound care as ordered (Residents #28, 32, and 73) for 3 of 3 sampled residents. Cross refer: F686: Based on record review, observation and interviews of the staff, nurse practitioner, and family member, the facility failed to assess and provide wound care for both heel pressure ulcers (Resident #28) and failed to consistently complete pressure ulcer care as ordered (Residents #28, 32 and 19) for 3 of 3 sampled residents. Findings included: On 12/7/21 at 3:46 pm an interview was conducted with the Administrator. She stated that the Director of Nursing (DON), wound treatment nurse, staff development coordinator, and unit manager were all on-call/rotate to cover licensed nursing call outs. She stated she knew that the treatment nurse carried an on-call phone and was required to be pulled to a nursing assignment any day of the week. She stated that she knew the treatment nurse had weekdays off when required to work on the weekend. The Administrator was informed that since June to date there were multiple omissions of nursing initials for wound care treatment on the resident ' s treatment administration record (TAR) and that the treatment nurse was interviewed and stated she signed for all the wound care she completed. The Administrator stated she was not aware that wound care was not completed as ordered. On 12/8/21 at 2:10 pm an interview was conducted with the infection preventionist (IP). The IP stated there was a high turnover of nursing staff, she had to wear many hats to cover, and was pulled to a nursing assignment when there was staffing shortage. The facility had hired two new unit managers and was phasing out the assistant director of nursing to help fill the gap. The facility also used agency staff for nursing shortage. On 12/8/21 at 3:30 pm an interview was conducted with the Director of Nursing (DON). The DON stated that there was a shortage of nursing staff due to resignations. The facility was using agency staff. When there was a call-out that could not be filled, the wound care nurse, unit supervisor or myself were responsible to cover the assignment. Nursing staff worked 12-hour shifts, and there were 2-day and 2-night shift, full-time nursing positions open. The DON stated that the shortest staffed and hardest to cover was Sunday staffing.