STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345177	A. BUILDING _____ B. WING _____	08/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE GREENS AT PINEHURST REHAB & LIVING CENTER	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident interview, and staff interview, the facility failed to place a resident ' s call light (Resident #10) within reach to allow for the resident to request staff assistance for 1 of 1 resident reviewed for accommodation of needs. The findings included: Resident #10 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A grievance form dated 6/2/20 for Resident #10 indicated a concern from the resident ' s family member related to Activities of Daily Living (ADL) care. The facility follow up of the grievance noted that the Social Worker (SW) spoke with Resident #10 and encouraged him to use his call light to request assistance. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #10 ' s cognition was fully intact. He had no behaviors and no rejection of care. He required the extensive assistance of 2 or more for bed mobility and supervision with set up help only for eating. He had functional limitations with range of motion on one side of his upper extremities. Resident #10 ' s active care plan indicated he was at risk for falls related to limitations that included, in part,[MEDICAL CONDITION] left sided [MEDICAL CONDITION]. The interventions included ensuring his call light was within reach and encouraging the resident to use it for assistance as needed. An observation and interview was conducted with Resident #10 on 7/26/20 at 12:50 PM. Resident #10 was alert and was lying on his adjustable bed in the flat position. His call light was attached by a clip to the bedsheet on the left side of his bed. Resident #10 ' s lunch tray was on the bedside table located on the right side of his bed. The resident reported that he needed staff assistance with bed mobility. He stated he was able to eat independently after set up. Resident #10 revealed he had not eaten his lunch meal as he was unable to find his call light to request assistance with adjusting his bed. He indicated he was unable to use his left hand and needed his call light to be placed on his lap or on the right side of his bed. An observation was conducted of Resident #10 on 7/27/20 at 12:10 PM. He was observed in bed in his room eating his lunch. His call light was clipped to the bedsheet on the left side of his bed. An observation was conducted of Resident #10 on 7/29/20 at 8:55 AM. He was observed in bed in his room with his call light placed across his lap and clipped to the sheet. An interview was conducted with Nursing Assistant (NA) #4 on 7/29/20 at 9:00 AM. NA #4 stated she was familiar with Resident #10 and that she was presently assigned to him. She reported that Resident #10 was unable to use his left hand. She indicated the resident utilized his call light to request assistance. NA #4 stated that Resident #10 needed to have his call light positioned across his lap as he was unable to ring the call light with his left hand. She revealed that if the call light was clipped to the left side of his bed he would not be able to reach it. An interview was conducted with NA #5 on 7/29/20 at 10:20 AM. NA #5 stated she was familiar with Resident #10 and that she was assigned to him on 7/26/20 and 7/27/20 during the 1st shift. She indicated that Resident #10 utilized his call light to request assistance. She stated that the resident was unable to use left hand, so he preferred to have his call light placed across his lap or on his right side. The observations on 7/26/20 at 12:50 PM and 7/27/20 at 12:10 PM of Resident #10 ' s call light clipped to the bed sheet on the left side of his bed were reviewed with NA #5. She confirmed that Resident #10 would not have been able to reach his call light in that position. NA #5 stated that she had not recalled his call light being in that position on 7/26/20 or 7/27/20 but indicated that lunch time was a busy time of day and it could have been in that position without her noticing it. She explained that during lunch time she and other staff were busy passing trays, setting up residents who were able to feed themselves, and providing assistance to residents who were not able to feed themselves. She further explained that due to these factors she may not have noticed if Resident #10 ' s call light was positioned out of his reach. An interview was conducted with the Director of Nursing (DON) on 7/29/20 at 2:59 PM regarding Resident #10 ' s call light not being placed within his reach. The DON indicated her expectations were for staff to place resident call lights within the residents ' reach at all times.
F 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with resident and staff, the facility failed to put resident to bed at her preferred time (Resident #9) for 1 of 3 sampled resident's reviewed for choices. Findings included: 1. Resident #9 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated the resident's cognition was intact, and she needed extensive assistance with bed mobility and transfer. The assessment further indicated that the resident did not have any behaviors. On 7/27/20 at 12:55 PM, Resident #9 was interviewed. She stated that her main concern was the facility did not have enough staff to provide care. She stated that she previously informed staff that her preferred bed- time was between 9:00 PM to 9:30 PM. But, staff do not assist her to bed until around 11:00 PM on most nights. Resident #9 explained that when she asked the staff to put her to bed at night, the staff would tell her that she had to wait because they didn't have enough help. An attempt to call the Nurse Aide (NA) assigned to Resident #9 during the 3:00 PM to 11:00 PM shift was unsuccessful. On 7/28/20 at 12:06 PM, Nurse #9, assigned on the hall Resident #9 resided, was interviewed. She stated that the hall has 40 or more residents to care for and only 1 nurse and 2 NAs assigned. The hall had a lot of residents, including Resident #9, that needed assistance with getting in and out of bed. Residents complained that they had to wait a long time to receive the care they needed. Nurse #9 verified that Resident #9 preferred to go to bed around 9:00 PM to 9:30 PM each night, but she had to wait until 11:00 PM or 11:30 PM to be put back to bed because there was not enough staff to transfer her into bed at her preferred time. On 7/29/20 at 3:01 PM, the Director of Nursing (DON) was interviewed. She stated that she assigned staff according to the facility census. She stated that she expected the staff to provide care according to the resident's choice including being assisted to bed at their preferred bedtime.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews with staff and residents and record review the facility failed to provide incontinent care for 1 of 3 dependent residents (Resident #3) reviewed for activities of daily living (ADL). The findings included: Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident's most recent comprehensive care plan, dated 7/1/2020, addressed triggered care areas including self-care performance deficit related to left sided [MEDICAL CONDITION]. Interventions listed on the care plan indicated the resident was total dependent for incontinent care and required extensive to total assistance by two persons. The most recent quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #3 had adequate hearing and vision and was able to make her needs known. Resident #3 was coded as being

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

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.

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) cognitively intact and without behaviors during the assessment period. The resident required physical assistance by two persons for bed mobility, transfers, activities of daily living (ADLs), toileting, and hygiene due to functional limitation of one upper and both lower extremities. Resident #3 was coded as always incontinent of bowel and bladder and required a wheelchair for locomotion. Continuous observations of Resident #3 on 07/27/20 from 10:22 am to 10:55 am (33 minutes) revealed staff failed to provide requested incontinent care to the resident during the following observations: Observations on 7/27/2020 at 10:22am revealed Resident #3 activated her call bell. At 10:23am the assistant activities director entered Resident #3's room and the resident stated that she needed to be cleaned up and gotten out of the bed to her wheelchair. The assistant activities director told Resident #3 that staff would assist her when she got the stuff off of her bed. The resident had papers lying on top of her bedding. The assistant activities director turned off the residents' call bell, exited the room. Observations on 7/27/20 at 10:25am revealed Resident #3 rang the call bell again and the assistant director of nursing (ADON) left the nurses's station and entered the resident's room within a minute. Resident # 3 informed the ADON that she had been waiting for assistance from staff since around 10:00am and stated she needed incontinence care and wanted to be dressed and placed in her wheelchair. The ADON turned off the resident's call bell and told the resident she would remind nursing assistant (NA) #2 that she needed assistance, but the NA was working with another resident at that time. The ADON was observed to exit the resident's room and returned to the nurse's station. Observations on 7/27/20 at 10:28am revealed Resident #3 rang the call bell again. The ADON left the nurses's station and entered the resident's room a second time. The resident stated she was becoming uncomfortable and wished to be cleaned up and gotten out of bed into her wheelchair. The ADON stated the NA was still working with another resident and indicated she could not help that the NA was not free to assist the resident. The ADON turned off the resident's call bell, left the resident's room and went back to the nurses's station. Observations on 7/27/20 at 10:29am revealed NA#1 walked past the door to Resident#3's room. The resident yelled out to her and asked her to help her. The NA entered the resident's room and explained to the resident she was on her way to assist another resident and the NA assigned to her area would be in as soon as she was available. The NA was overheard speaking kindly and professionally to the resident. The NA exited the room and answered the call bell for room [ROOM NUMBER]. Observations on 07/27/20 at 10:34am revealed the resident was in bed and was overheard yelling out for NA#2. The call bell was not on at the time. Observations on 7/27/20 at 10:54 am revealed NA#2 exited another resident's room with a bag of soiled linen. She entered the dirty linens room, exited the linens room, performed hand hygiene, and immediately entered Resident #3's room to provide incontinent care. An interview was conducted with Resident #3 on 7/27/2020 at 11:34am. She reported her first request for assistance with incontinent care, during the morning of 7/27/20, was around 10:00am. She further stated she felt the facility did not staff enough NAs and this resulted in her waiting long periods of time to receive care. Resident #3 stated the longest waits for care are common on all shifts and occur daily. An interview was conducted with NA #2 on 7/27/20 at 2:00pm. She stated there are usually 3 or 4 NAs scheduled to cover the residents on the 100 and 200 halls as well as covering any residents on what is known as the T-hall. On occasions, they may have a fourth NA. She stated there were only three NAs working first shift on 7/27/2020 and it was difficult to get to all the residents in a timely manner. Sometimes they are not able to get all of the resident care completed by the end of their shift. She stated there are several residents on the 100 and 200 like Resident #3, that require two-person assistance for incontinence care and transfers. She stated the NAs have had conversations with the ADON regarding the issue of not always having enough staff to provide care to all the residents. An interview was conducted with NA #1, at 2:50pm on 7/27/2020. She stated there are typically three or four NAs to cover the 100, 200, and T-hall residents. On first shift, 7/27/2020, there were only three NAs for first and second shift. She further stated it is difficult for three NAs to provide care to all the residents in a timely manner. She stated they do the best they can. She also indicated the NAs had brought the staffing issue to the attention of the ADON. An interview was conducted with NA#3 on 7/29/2020 at 9:15am. She stated there are three or four NAs assigned to the 100 hall, 200 hall, and the T-hall on most days. Some days there may be only 3 on second shift with a fourth NA for a portion of second shift. She stated on 7/27/2020 there were three NAs providing care on first and second shift. She further stated they do the best they can to meet the needs of the residents but some days residents do have to wait longer than others days for care by the NAs. An interview was conducted with the ADON on 7/27/2020 at 2:25pm. The ADON stated she considered 20 minutes to be a reasonable time for a resident to wait for incontinent care. She further stated the hall where Resident #3 resided was staffed with three NAs on 7/27/2020 and she felt three NAs were capable of meeting the needs of the residents in their assigned areas in a timely manner. A fourth NA was being used to provide one on one for a resident on the T hall on 7/27/2020. An interview was conducted with the Director of Nursing (DON) on 7/29/2020 2:55pm. The DON stated she expected incontinence care to be provided to residents at the time they utilize their call bell and make staff aware they are in need of incontinence care. She further stated all staff are expected to answer call bells. If the staff member is unable or not qualified to assist the resident, then the call bell should be left on and a qualified staff member should be made aware of the resident's needs. If the staff answering the call bell is qualified to assist the resident, then they should provide the requested care.
F 0725 **Level of harm** - Minimal harm or potential for 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.** Based on record reviews, observations, resident and staff interviews, the facility failed to provide sufficient nursing staff to provide incontinent care to 1 of 3 dependent residents reviewed for activities of daily living assistance (Resident #3), and put a resident in bed when requested (Resident #9) for 1 of 3 residents reviewed for choices. The findings included: This tag is cross referenced to: F677- Based on observations and interviews with staff and residents and record review the facility failed to provide incontinent care for 1 of 3 dependent residents (Resident #3) reviewed for activities of daily living (ADL). F561- Based on record review and interviews with resident and staff, the facility failed to put resident to bed at her preferred time (Resident #9) for 1 of 3 sampled resident's reviewed for choices. On 7/27/20 at 1:10m PM an interview was conducted with Nursing Assistant (NA) #8. She stated that facility was short of staff, and frequently had anywhere from 16 to 24 residents assigned to her. Residents had complained about call lights not answered in a timely manner, showers not provided, and long waits to receive care such as assistance getting out of or being put back into bed. Nurse #8 was interviewed on 7/27/2020 at 12:05pm. She stated she worked the third shift (7:00pm- 7:00am) and the staffing at night was inadequate with 1 nurse and 2 NAs for the hall with 45-47 residents. She further stated it was impossible to provide care for that many residents. Nurse #8 stated she had discussed issue with the DON, who kept promising to improve staffing. On 7/28/2020 at 2:52 pm an interview was conducted with Nurse #9. She stated she typically worked day shift but recently was pulled to help nights shift. She stated staffing on the skilled/rehab hall at night with one nurse and over 40 residents was inadequate. Nurse #9 specified that resident medications were often administered late. On 7/29/2020 at 10:45am an interview was conducted with the Assistant Director of Nursing (ADON) who also serves as the staff development coordinator. She stated there were three NAs working the long-term care halls (100,200, T-halls) and three NAs working the skilled rehab hall. She felt three NAs could meet the needs of the residents in a timely manner. On third shift, they were allowed three nurses for a census under 90 and 4 nurses if census was over 90. The fourth nurse, a med pass nurse, could work up to six hours, but not the entire 12 hour shift. When asked if the nurses and NAs had spoken with her regarding being unable to complete their workload, she stated they had and the facility was currently trying to hire additional nurses and NAs for the facility. She also stated staffing was based on census and not acuity of care and corporate ultimately made decisions on the number of staff that could be scheduled to work.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, the facility failed to discard expired medication and label medication with an open date for 3 of 3 medication carts observed for medication storage. (2 carts on 200 hallway and one cart on 100 hallway). Findings included: 1. On [DATE] at 10:30 am an observation of medications stored in the 200 hallway medication

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F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) cart was completed with Nurse #1. The following medications were observed stored in the medication cart: a [MEDICATION NAME] inhaler that was opened on [DATE] with a discard after 30 days sticker that was expired, the liquid [MEDICATION NAME] (stool softener) floor stock was opened on [DATE] and had a manufacturer date expired on ,[DATE], a resident ' s [MEDICATION NAME] nasal spray had no open date label and the manufacturer recommended to discard after open 28 days, a resident ' s [MEDICATION NAME] liquid (antipsychotic) was not dated when it was opened. There were 2 residents' [MEDICATION NAME] discus (inhaler) with no open date on the device. On [DATE] at 10:35 am an interview was conducted with Nurse #1 who stated that nursing was responsible to date label medication when opened and that pharmacy checked the cart for expired medication. Pharmacy was not entering the building due to COVID-19 and she did not know who was assigned to check for expired medication. Nurse #1 commented that she checked the date for medications she used. An interview was conducted on [DATE] at 1:30 pm with the Director of Nursing. She stated that medication storage check for expiration and labeling was assigned to the Unit Supervisor and nurses using the medication cart should be checking. 2. On [DATE] at 12:05 pm an observation was done of medication storage in the 300 hallway) medication cart with Nurse #2. There were 2 resident [MEDICATION NAME] nasal sprays with no open date stored in the medication cart. On [DATE] at 12:10 pm an interview was conducted with Nurse #2 who stated that pharmacy used to check the medication cart before COVID-19. Pharmacy does not enter the building during COVID-19. Cart check had not been assigned. Nurse #2 stated that he checked the medication expiration dates of the medications he used. Nurse #2 stated the [MEDICATION NAME] that was opened and not dated was managed by night shift. An interview was conducted on [DATE] at 1:30 pm with the Director of Nursing. She stated that medication storage check for expiration and labeling was assigned to the Unit Supervisor and nurses using the medication cart should be checking this as well. 2. On [DATE] at 11:15 AM, the medication cart on 200 hall (,[DATE] hall) was observed. There was a used bottle of Geri Lanta (liquid antacid drug) with an expiration date of ,[DATE], a used [MEDICATION NAME] (used to treat asthma and [MEDICAL CONDITIONS]) ,[DATE].5 inhaler that was undated, two used Incruse Ellipta inhalers (used to treat symptoms of [MEDICAL CONDITION]) that was undated , one used [MEDICATION NAME] (used to treat diabetes mellitus) 100 units/milliliter (ml) vial that was undated and one used [MEDICATION NAME] flex touch pen that was undated. The instruction on the box of the [MEDICATION NAME] inhaler read discard 3 months after removing from the foil pouch. The instruction on the box of the Incruse Ellipta inhaler read discard inhaler 6 weeks after opening the moisture protective foul tray or when the counter reads 0, whichever comes first. The counter read 13. The manufacturer's specification for [MEDICATION NAME] indicated to dispose 42 days after opening. On [DATE] at 11:20 AM, Nurse #7 was interviewed. She looked at the bottle of Geri Lanta and verified that it was already expired and stated that she would discard the expired bottle. The Nurse also had looked at the 2 inhalers of Incruse Ellipta, the [MEDICATION NAME] inhaler, the [MEDICATION NAME] vial and the [MEDICATION NAME] pen and verified that they were not dated when opened. She indicated that these medications should have been dated when opened but they were not. The Nurse stated that the nurses were supposed to check the medication carts every shift for expired and undated medications. On [DATE] at 11:25 AM, the Unit Manager (UM) on 200 hall was interviewed. The UM stated that the Pharmacist was responsible for checking the medication carts for expired and undated medications, however the Pharmacist had not been coming to the facility lately, she was reviewing the resident's records remotely. On [DATE] at 3:05 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the nurses to check the medication carts for expired and undated medications every shift and for the UM to check the medication carts a few times during the week. The DON also stated that she expected the manufacturer's specification for drug storage to be followed for the inhalers and insulin.
F 0842 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and record review, the facility failed to maintain complete and accurate medical records in the area of wound care for 2 (Resident #12 and Resident #11) of 2 residents reviewed for pressure ulcers. The findings included: 1. Resident #12 was admitted [DATE] with cumulative [DIAGNOSES REDACTED]. Resident #12's admission Minimum (MDS) data set [DATE] indicated severe cognitive impairment and he exhibited no behaviors. He was coded for one stage 2 pressure ulcer and one unstageable pressure ulcer present on admission. Resident #12's care plan dated 6/20/20 read he had 2 pressure ulcers present on admission with the intervention of administering his treatments as ordered. Resident #12's June 2020 Treatment Administration Record (TAR) revealed no documented information his pressure ulcer care was provided on 6/20/20 or 6/21/20. Resident #12's July 2020 TAR revealed no documented information his pressure ulcer care was provided on 7/2/20, 7/17/20 and 7/22/20. A wound care observation was conducted on 7/27/20 at 11:20 AM with the Treatment Nurse. She stated Resident #12's sacral pressure ulcer was noted to have an odor soon after admission and several courses of antibiotic rounds had been completed to aide in the wound's healing. She stated the Wound Physician saw Resident #12 weekly and had been [MEDICATION NAME] both his right heel and sacral pressure ulcers. There were no observed concerns with the treatment, status of the wounds or infection control measures. An interview was conducted on 7/29/20 at 10:15 AM with Nurse #4. He stated he worked 6/20/20 and 6/21/20 and completed Resident #12 treatments to his pressure ulcers but he forgot to document it on Resident #12's TAR. A telephone interview was conducted on 7/29/20 at 10:30 AM with Nurse #2. He stated the Treatment Nurse was pulled to work on the medication cart on 7/17/20 and 7/22/20 and he was assigned to complete Resident #12's pressure ulcer treatments. He stated he completed the treatments but he forgot to document it on Resident #12's TAR. A telephone interview was conducted on 7/29/20 at 10:35 AM with Nurse #5. She stated she recalled completing Resident #12's pressure ulcer treatments on 7/2/20 but due to multiple interruptions from families calling to inquire about their loved ones or request to do window visits, she forgot to document it on Resident #12's TAR. An interview was conducted on 7/29/20 at 2:35 PM with the Treatment Nurse. She stated she was often pulled to work the floor passing medications. She stated when this happened, the hall nurses were responsible for completing their own treatments. The Treatment Nurse stated she knew Resident #12's pressure ulcer treatments were done because she would look at the date on the dressings to see when they were last changed. An interview was conducted on 7/29/20 at 2:57 PM, the Director of Nursing stated it was her expectation that the nurses document on the TAR once the treatment was provided to ensure accurate and complete medical records. 2. Resident # 11 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated that the resident had long and short-term memory problems and had impaired decision-making skills. The assessment further indicated that the resident had a stage IV pressure ulcer. Resident #11 had a doctor's order dated 7/8/20 to clean the pressure ulcer with Normal Saline (NS) and to apply nickel thick layer of Santyl ([MEDICATION NAME] agent) to wound bed, pack with Calcium alginate (used to absorb heavy exudate)) and cover with absorbent dressing daily and as needed. The July 2020 Treatment Administration Record (TAR) of Resident #11 was reviewed. The TAR did not have nurse's initial to indicate that the treatment was provided to the pressure ulcer on 7/12/20, 7/15/20, 7/18/20 and 7/23/20. On 7/28/20 at 5:10 PM, the Treatment Nurse was interviewed. She stated that she was pulled to work on the floor on 7/12/20, 7/15/20 and 7/18/20 and the floor nurses were supposed to provide the treatment to the resident's pressure ulcer. She also stated that she had provided the treatment to the resident's pressure ulcer on 7/23/20 but she failed to put her initial on the TAR to indicate that the treatment was provided. On 7/29/20 at 8:10 AM, Nurse #8 was interviewed. Nurse #8 was assigned to Resident #11 on 7/15/20 and 7/18/20. She stated that she had provided the treatment to the resident's pressure ulcer on 7/15/20 and 7/18/20 but did not put her initial on the TAR to indicate that the treatment was provided. She indicated that she just started working at the facility and was still learning. On 7/29/20 at 3:05 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the nurses to put their initials on the TAR to indicate that the treatment was provided.