

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OCT 17 2012

PRINTED: 10/12/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/28/2012
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NAME OF PROVIDER OR SUPPLIER ROANOKE RIVER NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 119 GATLING STREET WILLIAMSTON, NC 27892
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION OF Roanoke River Nursing and Rehabilitation Center	(X5) COMPLETION DATE
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to preserve dignity for 1 of 2 sampled dependent residents (Resident #2) who was observed on 2 different occasions in the hallway with wet soiled clothing. The facility also failed to ensure that dignity for 1 of 1 sampled dependent residents (Resident #5) was maintained as evidenced by being left in bed on urine soaked linens. Findings include:</p> <p>1. Resident # 2 was admitted to the facility on 08/26/10 and readmitted on 04/19/11. Cumulative diagnoses included alzheimer's disease.</p> <p>The Annual Minimum Data Set (MDS) of 09/09/12 indicated she had severely impaired cognitive skills. There were no behaviors noted. She required extensive to total assistance with toilet use and hygiene. She was incontinent of both bowel and bladder.</p> <p>On 09/26/12 beginning at 1:45 PM, a continuous observation was conducted for Resident #2. She was observed self-propelling in the hallway in her specialty wheelchair. It was noted that the entire crotch of her navy sweat pants was darkened in color with the discoloration up towards the</p>	F 241	<p>acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance.</p> <p>Roanoke River Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Roanoke River Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patrick Clark TITLE: Administrator (X6) DATE: 10/17/12

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 241	<p>Continued From page 1</p> <p>waistline of her sweat pants. The dark area extended down her inner right thigh. There was a distinct stool odor detected as she propelled down the hallway. As she propelled herself down the hallway, visitors as well as staff members passed her by and in passing would stop to talk with Resident #2. She was observed continuously until 2:15 PM on 09/26/12 when Nurse Aide #1 (NA#1) was observed pulling her from the hallway backwards into her room. When questioned about what she was about to do, she stated she was going to clean her up. Upon entrance into the room, a strong stool odor was detected. Upon observation, the crotch and upper legs of the sweat pants were saturated with soft mushy brown stool when removed. NA#1 provided incontinent care for Resident #2.</p> <p>During an interview with NA#1, on 09/26/12 at 2:50 PM, she stated she usually started her last rounds after the lunch trays were off the hall. She stated she did not usually work on the floor with a routine assignment as she floated on different halls. NA#1 commented that the last time she had checked Resident #2 was around 11:00 AM. She stated she had numerous duties that had to be completed during her shift and she checked residents as often as she could.</p> <p>A continuous observation was conducted beginning on 09/28/12 at 10:45 AM. Resident #2 was observed self propelling in her speciality wheelchair at the far end of the hallway on 09/28/12 at 10:45AM. As she propelled down the hallway, it was noticed that there was a large dark wet area which appeared to encompass the entire crotch of her pink sweat pants that extended down her inner right thigh and left thigh.</p>	F 241	<p>F 241 483.15(a) Dignity and Respect of Individuality</p> <ol style="list-style-type: none"> Resident's #2 and 5 were reviewed for proper and timely incontinent care on 10/1/12 by the Director of Nursing (DON) 100% of resident's, including #2 and 5, have been audited for proper and timely incontinent care on 10/16/12 by Administrative Nursing Team. 100% in-servicing of nursing staff on Proper and Timely Incontinent care, and Dignity Issues completed on 10/22/12 by Staff Facilitator or designee. <p>Care audits will be completed by Administrative nursing staff 3 times per week X's 4 weeks, then weekly X's 4 and then monthly X's 3 months using a QI tool.</p>	10/26/12

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F 241	<p>Continued From page 2</p> <p>Staff were observed walking by her speaking and chatting with her as she self propelled in the hallway. Family members visiting other residents were observed walking by and speaking to her. She propelled herself down towards her room. She was continuously observed until 11:15 AM on 09/28/12 when NA#2 walked down the hallway towards Resident #2. She commented to Resident #2 that she needed to take her to her room. She wheeled Resident #2 into her room and left her sitting in the room. NA#2 came out of the room and began charting in the computer located in the hallway. As she was documenting on the computer, the speech therapist approached Resident #2 at 11:20 AM and asked NA#2 if she could take her to the day room. NA#2 responded that yes she could and she would provide care for her after she finished her therapy session.</p> <p>NA#2 was interviewed at 11:25 AM on 09/28/12. When questioned if she needed to provide care before the interview started, she stated that she would provide Incontinent care for her after therapy finished. NA#2 commented that therapy usually kept Resident #2 for about 10 or 15 minutes. She stated she checked the residents on her assignment every 2 hours. She stated the last time she checked Resident #2 was around 9:00 AM. NA#2 stated Resident #2 was total care and could not make her needs known.</p> <p>Resident #2 was observed sitting in the day room with the speech therapist on 09/28/12 at 11:30AM. She had a lollipop in her mouth and the therapist was talking with her. At 11:35 AM, the therapist stated she would return her to her room. The therapist asked Resident #2 if she</p>	F 241	4. The Executive QI committee will meet and review audits to identify and address concerns and/or trends and to follow up as necessary and to determine the frequency and the need for continued monitoring weekly X4, then monthly X3.		

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F 241	<p>Continued From page 3</p> <p>had spilled something on her clothing. Then she stated she definitely needed to take her to her room as it looked as if she had wet herself. She reported to Resident #2 that NA#2 could provide care for her before having her lunch tray. The speech therapist pushed her to her room at 11:40AM and told Resident #2 that NA#2 would be in to dry her up.</p> <p>At 11:45 AM on 09/28/12, NA#2 was observed rolling the mechanical lift device into the room. After placing her onto the bed, NA#3 was in to assist her with care for Resident #2. It was noted that Resident #2 had soft mushy brownish stool covering the inside of her sweat pants when NA#2 removed them. After they had provided incontinent care to Resident #2, they transferred her back to the wheelchair.</p> <p>NA#2 was interviewed at 2:30 PM on 09/28/12. She stated she had changed Resident #2 at around 9:00 AM and she did not have a bowel movement when she changed her. She stated Resident #2 had been having looser more frequent stools the last day or so sometimes more than one on her shift. NA#2 commented the nurse was aware. She reported that Resident #2 usually had stools about this time every day or right after she finished lunch. When questioned about allowing the speech therapist to take her to the day room soiled, she responded she thought Resident #2 could wait until therapy was finished. She reported she had no explanation as to why she did not provide care prior to documenting her information into the computer in the hallway. NA#2 commented that she was busy when she walked towards Resident #2 and really did not notice if she was wet or not.</p>	F 241			

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F 241	<p>Continued From page 4</p> <p>NA#2 also commented that it was about time to check her and that was the reason she rolled her into her room and not because she noticed she was wet or soiled.</p> <p>During an interview with the Assistant Director of Nurses (ADON), on 09/28/12 at 2:45 PM, she stated her expectation was that staff check residents every 2 hours for incontinence. She stated staff knew which residents were having frequent or loose stools and which residents were heavy wetters. The ADON stated staff should be checking those residents more often to preserve their dignity. She stated it was not acceptable for Resident #2 or any resident to be in the hallway with an obvious incontinent episode on their clothing. She commented the fact that Resident #2 was in the hallway on 2 different occasions with obvious incontinence on her clothing was not acceptable at all. The ADON commented that the aide should have provided care before she went to the day room.</p> <p>2. Resident #5 was admitted to the facility on 01/20/10. Cumulative diagnoses included cerebrovascular accident, vascular dementia and aphasia.</p> <p>The Annual Minimum Data Set (MDS) of 05/08/12 indicated Resident #5 had moderately impaired cognitive skills. He needed total assistance with hygiene, bathing and toilet use. He was incontinent of both bowel and bladder. He needed total assistance with activities of daily living.</p> <p>The most recent Quarterly Minimum Data Set (MDS) assessment of 08/06/12 indicated</p>	F 241		

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F 241	<p>Continued From page 5</p> <p>Resident #5 had severely impaired cognitive skills. He needed total assistance for dressing, bathing, hygiene and toilet use. Resident #5 was also noted to be incontinent of both bowel and bladder.</p> <p>Resident #5 was observed in bed wearing a gown on 09/28/12 at 10:45 AM. There was a distinct urine odor detected. When questioned if he could use his call bell to call for assistance, he had no response. His roommate was in the room and stated staff had not been in to bathe Resident #5.</p> <p>During a bed bath observation, on 09/28/12 beginning at 11:55 AM, Nurse Aide #4 (NA#4) and Nurse Aide #5 (NA#5) were in the process of bathing Resident #5's face, upper chest, arms and hands. There was a distinct urine odor detected. It was noted that there was a large halo of yellow stains noted on the sheet where Resident #5 was positioned that extended out both sides and around Resident #5. It appeared to be saturated with urine. When the wet sheet was removed, it was noted that the bed had a darkened area where the sheet had been indicating the bed mattress was wet as well. Both aides finished the bath, dressed him in shorts and a t-shirt and transferred him via mechanical lift to his wheelchair.</p> <p>NA#4 was interviewed at 12:25 PM on 09/28/12. NA#4 stated she was working with NA#5 in an effort to get everyone bathed before lunch. When questioned about the last time they were in to provide care for Resident #5, NA#4 responded that this was the first time any care had been provided for him since third shift left. NA#4</p>	F 241			

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F 241	Continued From page 6 stated Resident #5 was a heavy wetter and needed to be checked often. She also stated he was mostly non-verbal. When questioned if the sheet and bed was wet with urine, she responded that yes the bed was wet and she had noticed it. NA#5 stated she didn't usually work the floor but due to several staff call outs today she had been pulled to provide care. During an interview with the Assistant Director of Nurses (ADON), on 09/28/12 at 2:45 PM, she stated her expectation was for staff to check on residents at least every 2 hours. She stated if a resident was known to be a heavy wetter the staff should be checking on them more often. The ADON commented that allowing a resident to be in bed on urine soaked sheets was not acceptable. She also commented that it was unacceptable for staff to leave him in bed since the beginning of the shift and not check to see if he needed care. The ADON added that his dignity was not maintained.	F 241		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide timely incontinent care for 1 of 2 sampled dependent residents (Resident #2) whose care was	F 312	F 312 483.25(a) (3) ADL Care Provided for Dependent Residents 1. Residents #2 and 5 were audited for nail care completed on 10/1/12 by DON. Resident #5 was audited on bed baths to include rinsing the soap completed on 10/16/12 by Asst Director of Nursing (ADON). 2. 100% audited on resident's nails was completed on 10/15/12 by designated Certified Nursing Asst. supervised and signed off on by the DON. Administrative Nursing Team completed 100% audit on residents using bar soap on 10/17/12.	10/26/12

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F 312	<p>Continued From page 7</p> <p>observed on 2 different occasions. The facility failed to provide complete incontinent care for 1 of 2 sampled dependent residents (Resident #5) whose care was observed. The facility failed to provide a complete bed bath as evidenced by not rinsing away the soap from the body for 1 of 1 sampled dependent residents (Resident #5) whose care was observed. The facility also failed to provide grooming services for 2 of 2 sampled dependent residents (Resident #2 and Resident #5) who were observed with black matter underneath fingernails. Findings include:</p> <p>1. Resident #2 was admitted to the facility on 08/26/10 and readmitted on 04/19/11. Cumulative diagnoses included alzheimer's disease, congestive heart failure and depression.</p> <p>The Annual Minimum Data Set (MDS) of 09/09/12 indicated she had severely impaired cognitive skills. There were no behaviors noted. She required extensive to total assistance with toilet use and hygiene. She was incontinent of both bowel and bladder. According to the Care Area Assessment (CAA) trigger detail, she triggered in 10 areas including urinary incontinence.</p> <p>Resident #2's most current care plan, last reviewed 07/25/12, identified problems with urinary incontinence and risk for skin breakdown. The goal for the urinary incontinence care plan was to be free of urinary tract infections. Included in the interventions for the urinary incontinence problem was to provide peri-care after each incontinent episode. The care plan for risk for skin breakdown indicated she was incontinent and at high risk for pressure ulcer development.</p>	F 312	<p>3. 100% in-servicing of staff on Nail Care, Proper Incontinent care (Male/Female), using barrier cream and Rinsing bar soap during a bed bath completed on 10/22/12 by Staff Facilitator or designee. Care audits will be completed by Administrative nursing staff 3 times per week X's 4, then weekly X's 4 and then monthly X's 3 months using a QI tool.</p> <p>4. The Executive QI committee will meet and review audits to identify and address concerns and/or trends and to follow up as necessary and to determine the frequency and the need for continued monitoring weekly X's 4, then monthly X' 3 months.</p>		

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F 312	<p>Continued From page 8</p> <p>Included in the interventions for being at risk for skin breakdown was to provide incontinence care after each incontinent episode or toileting.</p> <p>1 a. The facility's incontinence care policy, version 4/2007, indicated perineal care was to be provided after each incontinent episode.</p> <p>On 09/26/12 at 1:45 PM, Resident #2 was observed self-propelling in the hallway in her specialty wheelchair. Upon closer observation, it was noted that the entire crotch of her navy sweat pants was darkened in color with the discoloration up towards the waistline of her sweat pants. The dark area extended down her inner right thigh. There was a distinct stool odor detected as she propelled down the hallway. At 2:15 PM on 09/26/12, Nurse Aide #1 (NA#1) was observed wheeling Resident #2 backwards into her room. When questioned about what she was about to do, she stated she was going to clean her up. Upon entrance into the room, a strong stool odor was detected. Resident #2 was using her right arm to rub her pants back and forth where the wet dark area was on the sweat pants. She positioned the mechanical lift device up to the specialty wheelchair, after applying the sling she lifted her up and transferred her to the bed. Once she positioned her on the bed and removed the sling, she removed her shoes and her sweat pants. It was noted that she had soft mushy brownish stool on the inside of her sweat pants. Her brief appeared to be filled with soft stool which had seeped out the sides of the diaper onto her inner thighs. She removed the diaper to reveal very large amounts of soft mushy brownish stool which extended from the buttocks, perineal area and up to just above her pubic hair on her</p>	F 312			

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F 312	<p>Continued From page 9</p> <p>abdomen. NA#1 used disposable wipes to remove the stool from the buttocks area. She continued to use disposable wipes cleansing front to back numerous times to remove the soft stool. Once she had removed the stool, she placed a clean brief. She did not apply any type of barrier cream.</p> <p>During an interview with NA#1, on 09/26/12 at 2:50 PM, she stated she did not use soap and water due to time constraints as she needed to finish her rounds. She stated she felt she had cleaned away all of the soft stool with the disposable wipes. NA#1 reported Resident #1 to be a heavy wetter. When questioned as to how often she checked residents for incontinence, she responded she usually started her last rounds after the lunch trays were off the hall. NA#1 commented that the last time she had checked Resident #2 was around 11:00 AM.</p> <p>During an interview with the Assistant Director of Nurses (ADON), on 09/28/12 at 2:45 PM, she stated her expectation was that staff check residents every 2 hours for incontinence. She stated staff knew which residents were having frequent or loose stools and which residents were heavy wetters. The ADON stated staff should be checking those residents more often to preserve their dignity. She stated it was not acceptable for Resident #2 or any resident to be in the hallway with an obvious incontinent episode on their clothing. She stated after incontinent episodes, staff should be applying either vaseline or oil as a protectant.</p> <p>1b. Resident #2 was observed self propelling in her speciality wheelchair at the far end of the</p>	F 312			

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F 312	<p>Continued From page 10</p> <p>hallway on 09/28/12 at 10:45 AM. As she propelled down the hallway, it was noticed that there was a large dark wet area which appeared to encompass the entire crotch of her pink sweat pants that extended down her inner right thigh and left thigh. She propelled herself down towards her room. At 11:15 AM, NA#2 walked down the hallway towards Resident #2 and told her she needed to take her to her room. She wheeled Resident #2 into her room and left her sitting in the room. NA#2 came out of the room and began charting in the computer located in the hallway. As she was documenting on the computer, the speech therapist approached Resident #2 at 11:20 AM and asked NA#2 if she could take her to the day room. NA#2 responded that yes she could and she would provide care for her after she finished her therapy session. At 11:25 AM, NA#2 was asked if she needed to provide care to Resident #2 and she responded she would care for her after therapy finished.</p> <p>NA#2 was interviewed at 11:25 AM on 09/28/12. She stated she checked the residents on her assignment every 2 hours. She stated the last time she checked Resident #2 was around 9:00 AM. NA#2 commented that therapy usually kept Resident #2 for about 10 or 15 minutes.</p> <p>At 11:40 AM on 09/28/12, NA#2 was observed rolling the mechanical lift device into the room. NA#3 was in to assist her provide care for Resident #2. After they transferred her to the bed, they left the sling from the lift device in place. NA#2 began to remove her sweat pants. As she removed them, it was noted that there was soft mushy brownish stool on the inside of the sweat pants as she pulled them down</p>	F 312		

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F 312	<p>Continued From page 11</p> <p>Resident #2's legs. The back of the sweat pants was noted to be soaked with urine and/or stool. The entire crotch area and the inner legs of the sweat pants were also saturated with stool and/or urine. Soft brownish mushy stool was seeping from the sides of the soiled brief. NA#2 used numerous disposable wipes to clean away the loose stool which extended from the upper buttocks covering the perineal area and up past her pubic hair. After she finished removing the stool, she dressed Resident #2 in blue pants and transferred her back to her wheelchair. She did not apply any barrier cream to her buttocks or perineum area.</p> <p>NA#2 was interviewed at 2:30 PM on 09/28/12. She stated she had changed Resident #2 at around 9:00 AM and she did not have a bowel movement when she changed her. She stated Resident #2 had been having looser more frequent stools sometimes more than one on her shift. NA#2 commented the nurse was aware. She reported that Resident #2 usually had stools about this time every day or right after she finished lunch. When questioned about allowing the speech therapist to take her to the day room soiled, she responded she thought Resident #2 could wait until therapy was finished. She reported she had no explanation as to why she did not provide care prior to documenting her rounds in the computer. NA#2 commented that she was busy when she walked towards Resident #2 and really did not notice if she was wet or not. NA#2 also commented that it was about time to check her and that was the reason she rolled her into her room.</p> <p>During an interview with the Assistant Director of</p>	F 312			

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F 312	<p>Continued From page 12</p> <p>Nurses (ADON), on 09/28/12 at 2:45 PM, she stated her expectation was that staff check residents every 2 hours for incontinence. She stated staff knew which residents were having frequent or loose stools and which residents were heavy wetters. The ADON stated staff should be checking those residents more often to preserve their dignity. She stated it was not acceptable for Resident #2 or any resident to be in the hallway with an obvious incontinent episode on their clothing. She stated after incontinent episodes, staff should be applying either vaseline or oil as a protectant.</p> <p>1 c. The facility's procedure for providing a bed bath, version date 02/2007, indicated the objective was to cleanse, refresh and soothe the resident. It was noted in this procedure that care of the finger and toenails was part of the bath. "Be certain nails are clean."</p> <p>Resident #2 was observed sitting in a specialty wheelchair on 09/26/12 at 9:30 AM. It was noted that there was black matter underneath the fingernails on both hands.</p> <p>Resident #2 was observed in the hallway in her specialty wheelchair on 09/27/12 at 8:25 AM. It was noted that there was black matter underneath the fingernails on both hands.</p> <p>On 09/27/12 at 11:00 AM, Resident #2 was observed self-propelling in the hallway in her specialty wheelchair with the black matter noted underneath the fingernails on both hands.</p> <p>Resident #2 was observed in the hallway in her specialty wheelchair again on 09/27/12 at 5:00</p>	F 312			

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F 312	<p>Continued From page 13</p> <p>PM. The black matter remained underneath the fingernails on both hands.</p> <p>NA#2 reported during an interview on 09/28/12 at 11:25 AM that she soaked the resident ' s fingernails daily when she provided bed baths. She stated Resident #2 ate with her hands at times as she would not use utensils. NA#2 stated resident's fingernails should be cleaned daily.</p> <p>Incontinent care was provided for Resident #2 at 11:40 AM on 09/28/12. After NA#2 finished providing the care, she was observed looking at her fingernails and told Resident #2 she would clean them after lunch.</p> <p>During a lunch observation of Resident #2 in the restorative dining room, on 09/28/12 at 1:15 PM, she was observed placing two fingers on her right hand into a dish of chocolate pudding. She placed the two fingers in her mouth and licked the pudding from her fingers. She continued to eat her lunch with utensils.</p> <p>The Assistant Director of Nurses (ADON) was assisting residents in the restorative dining room where Resident #2 was eating on 09/28/12 at 1:30 PM. The ADON was asked to check Resident #2's fingernails. She stated she would clean the black matter from her fingernails with a wet wipe when she finished eating. At 1:35 PM, the ADON used the wet wipe to remove the black matter from her fingernails.</p> <p>During an interview with the ADON, on 09/28/12 at 2:45 PM, she stated her expectation was that staff wash the resident's hands and clean the fingernails daily with the morning bath. She</p>	F 312		

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F 312	<p>Continued From page 14</p> <p>stated Resident #2's fingernails were in need of cleaning.</p> <p>2. Resident #5 was admitted to the facility on 01/20/10. Cumulative diagnoses included cerebrovascular accident, depression, diabetes mellitus, vascular dementia and aphasia.</p> <p>The Annual Minimum Data Set (MDS) of 05/08/12 indicated Resident #5 had moderately impaired cognitive skills. He needed total assistance with hygiene, bathing and toilet use. He was incontinent of both bowel and bladder. According to the Care Area Assessment (CAA) detail for this assessment, he triggered in 12 areas including activities of daily living and urinary incontinence. He needed total assistance with activities of daily living.</p> <p>The most recent Quarterly Minimum Data Set (MDS) assessment of 08/06/12 indicated Resident #5 had severely impaired cognitive skills. He needed total assistance for dressing, bathing, hygiene and toilet use. Resident #5 was also noted to be incontinent of both bowel and bladder.</p> <p>2 a. The facility's procedure for providing a bed bath, version date 02/2007, indicated the objective was to cleanse, refresh and soothe the resident. It was noted in this procedure to wash, rinse and dry the body parts carefully.</p> <p>Resident #5's care plan, last reviewed 08/15/12, identified a problem with being at risk for skin breakdown related to cognitive impairment and immobility. Interventions included providing incontinence care after each incontinent episode.</p>	F 312			

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F 312	<p>Continued From page 15</p> <p>There was no problem identifying activities of daily living in the care plan.</p> <p>On 09/26/12 at 11:25 AM, Nurse Aide #4 (NA#4) prepared to provide a complete bed bath for Resident #5. She placed a bar of green soap into the empty basin and filled it with warm water. As the basin filled, a large amount of suds was noted. As she washed using a wash cloth and lots of suds, she bathed his face, neck and upper body. After she washed the upper body, she used a dry towel to dry the suds off of his body. She did not rinse the soap from his skin. She changed the basin of water. She again filled the basin with warm water with the soap in the bottom of the basin causing lots of suds to form. She washed the lower body including the perineal area using a different washcloth and lots of suds. Afterwards, she dried with a dry towel again not rinsing the soap from his body. When she finished the bath, she applied baby oil to his body. Then she dressed him in tan slacks and a dark green t-shirt in preparation to lift him into the wheelchair.</p> <p>During an interview with NA#4 on 09/27/12 at 9:10 AM, she stated she did not usually rinse the soap off when she provided a bed bath to Resident #5. She stated she usually dried it off using a dry towel. She stated the facility also provided soap for use if the resident did not have their own soap.</p> <p>During an interview with the Director of Nurses (DON), on 09/27/12 at 4:55 PM, she stated if staff provide bed baths using the resident's personal bar soap, they should be rinsing the soap from the resident's body.</p>	F 312			

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F 312	<p>Continued From page 16</p> <p>2 b. The facility's procedure for providing a bed bath, version date 02/2007, indicated the objective was to cleanse, refresh and soothe the resident. It was noted in this procedure that care of the finger and toenails was part of the bath. "Be certain nails are clean."</p> <p>During a lunch meal observation in the dining room of Resident #5, on 09/26/12 at 12:45 PM, he was observed eating a biscuit with his right hand. There was black matter noted underneath all of the fingernail beds on the right hand.</p> <p>Resident #5 was observed sitting up in bed on 09/27/12 at 8:20 AM. He was eating breakfast. It was noted that the black matter remained underneath the fingernails on both hands.</p> <p>On 09/27/12 at 11:30 AM, Resident #5 was observed in his wheelchair with the black matter noted underneath the fingernails on both hands.</p> <p>Resident #5 was observed in his wheelchair sitting in the hallway with his hands crossed one over the other at 5:00 PM on 09/27/12. There was black matter noted underneath the fingernails on both hands.</p> <p>During another observation of Resident #5, on 09/28/12 at 10:45 AM, he was in bed and the black matter remained underneath the fingernails on both hands.</p> <p>On 09/28/12 at 1:45 PM, Resident #5 was observed having lunch in the dining room. The black matter was still noted underneath the fingernails on both hands. The Administrator</p>	F 312		

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F 312	<p>Continued From page 17</p> <p>asked Resident #5 if she could see his hands, when he held up his hands she stated she would have someone clean underneath his fingernails as they were in need of cleaning.</p> <p>During an interview with the Assistant Director of Nurses (ADON), on 09/28/12 at 2:45 PM, she stated nail care should be provided daily during the bed bath. She stated staff should be washing the resident's hands and cleaning underneath the fingernails to remove any material from the nail bed and tip of the finger.</p> <p>2 c. Resident #5's care plan, last reviewed 08/15/12, identified a problem with being at risk for skin breakdown related to cognitive impairment and immobility. Interventions included providing incontinence care after each incontinent episode.</p> <p>During an observation of Resident #5, on 09/26/12 at 5:20 PM, he was sitting in the wheelchair in the hallway. It was noted that the entire crotch on the front of his slacks was wet.</p> <p>On 09/26/12 at 5:45 PM, Nurse Aide #6 (NA#6) was observed attempting to place the positioning strap for the sit to stand mechanical lift device around Resident #5's waist. She had placed the leg strap around his lower legs. She stated she was having difficulty as he did not understand what she was asking him to do so she yelled out to a passing staff member for assistance. Nurse Aide #7 (NA#7) came into the room to assist her. After the waist strap was connected, NA#7 lifted Resident #5 up enough for NA#6 to pull his slacks down so she could wash him. It was noted that the entire crotch area, seat of the slacks and</p>	F 312			

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F 312	<p>Continued From page 18</p> <p>the upper part of both legs of the slacks were soaked with urine. NA#6 used a disposable wipe to wipe across the upper pubic area and wiped across the buttocks from left to right and disposed of the wipe. She placed a clean brief and NA#7 transferred him to the bed. Once Resident #5 was positioned on the bed, NA#6 removed his slacks. She asked if he wanted to stay in bed and Resident #5 nodded that he did. NA#6 did not provide cleansing of the perineal area, scrotum or buttocks, she did not push back the foreskin, she did not wash the penis nor did she wash his inner thighs to remove the urine.</p> <p>NA#6 was interviewed immediately after the observation on 09/26/12 at 6:00 PM. She stated she had provided incontinent care for Resident #5 about 30 minutes prior to this episode. She stated she had cleaned him thoroughly at that time and felt that wiping him down briefly was sufficient. NA#6 stated she was in a hurry as she was assigned to assist in the dining room. She reported she should have washed all of his body parts as both the front and back of his body had been in contact with the urine. NA#6 commented that the facility did provide barrier cream for use on incontinent residents but she did not use it.</p> <p>The Assistant Director of Nurses (ADON) was interviewed on 09/28/12 at 2:45 PM. She stated staff were expected to check residents every 2 hours for incontinence. She stated if a resident was known to be a heavy wetter staff should be checking them more often. The ADON reported that thorough cleansing should be done after each incontinent episode which included pushing the foreskin back on the uncircumcised male to properly cleanse away the urine. She stated the</p>	F 312		

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F 312	Continued From page 19 entire perineum including the penis and the scrotum and any other areas that came into contact with the urine should be cleansed.	F 312	1. Resident #3 (L) knee immobilizer was discontinued on 10/15/12. Registered dietitian reviewed resident and chart on 9/28/12. Wound assessments for resident was reviewed and up dated as needed on 9/28/12 by treatment nurse(s). 2. 100% audit on all residents with immobilizer/splints for skin checks was completed on 10/18/12 by ADON. All residents with wounds were audited for Registered Dietitian consults completed on 10/16/12 by the Administrator. All residents with wounds were audited for timely wound assessments completed on 10/11/12 by DON.	10/26/12	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, physician interview, staff interview, resident interview, and record review facility staff failed to apply a knee immobilizer correctly which contributed to the development of pressure ulcers (left lower leg) which were not identified until they presented as unstageable wounds for 1 of 3 sampled residents (Resident #3) with pressure ulcers. The facility also failed to measure and assess a pressure ulcer (left buttock/sacrum) for 13 days after it was identified, and failed to put nutritional interventions in place to help heal this ulcer in a timely manner and provide a consult with the registered dietitian as recommended by the dietary manager for 1 of 3 sampled residents (Resident #3) with pressure ulcers. Findings include: Resident #3 was admitted to the facility on 10/01/05. The resident's documented diagnoses	F 314			

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F 314	<p>Continued From page 20</p> <p>included pressure ulcers, diabetes, peripheral vascular disease (PVD), and bilateral tibia fractures (as documented by 08/30/12 x-rays).</p> <p>a. Labs collected on 06/22/12 documented Resident #3's albumin level was within normal limits, 3.7 grams per deciliter (g/dL) with normal being 3.5 - 5.2 g/dL.</p> <p>X-rays taken on 08/30/12 documented Resident #3 had bilateral tibia fractures.</p> <p>A 08/31/12 physician's order documented Resident #3 was to be sent out to the hospital for bilateral knee immobilizers.</p> <p>The resident's 09/05/12 Significant Change Minimum Data Set (MDS) documented her cognition was moderately impaired, and she required extensive assistance from two staff members for bed mobility.</p> <p>On 09/12/12 "Ulceration or interference with structural integrity of layers of skin caused by prolonged pressure related to: incontinence-bowel and/or bladder, immobility, total assistance needed with turning & positioning" was identified as a problem on the resident's care plan. Interventions to this problem included, "Monitor skin daily during care for any changes. Report any abnormal observations to nurse" and "Notify appropriate personnel of changes in eating/drinking patterns. Interventions also included, "Weekly assessment of wound/ulcer. Notify physician of changes as indicated."</p> <p>A 09/15/12 electronic Resident Progress Note</p>	F 314	<p>3. 100% in-servicing for staff of Procedure for reporting Skin referrals, Reporting residents pain to nurse, Applying immobilizers/splints correctly and reports skin issues completed on 10/22/12 by the Staff Facilitator or designee.</p> <p>Treatment nurses in-serviced per Wound Consultant, Vera Stanley on 10/18/12 timely assessment procedure completed on .</p> <p>Proper placement of immobilizers/splints with reporting skin issues, reporting pain and timely wound assessment and RD consults will be audited 3 X's weekly X's 4, then weekly X's 4, then monthly X's 3 using a QI tool.</p>	

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F 314	<p>Continued From page 21</p> <p>documented, "...Leg immobilizers in place to bilat (bilateral) lower extremities ...Swelling remains of extremities @ (at) knees and below. Pedal pulses present bilat. Resident keeps feet externally rotated. Propped with pillow to prevent rotation. Receives pain medication as prescribed."</p> <p>A 09/19/12 electronic Resident Progress Note documented, "Resident lying in bed, c/o (complains of) pain to Lt (left) leg. Stated leg felt like it was bleeding. Immobilizer loosened on leg. Bruising and swelling @ & (at and) below knee. No bleeding present. Pedal pulse present bilat (bilaterally). Legs positioned for comfort."</p> <p>A 09/20/12 physician's order clarified that the bilateral knee immobilizers, which the resident received on 08/31/12, were to be in place for Resident #3 at all times unless the resident was being bathed.</p> <p>A 09/24/12 electronic Wound/Ulcer Flow Sheet documented the presence of two pressure ulcers on Resident #3's left lower leg. The sheet documented the ulcer on the proximal left lower leg measured 2 x 1.5 centimeters (cm), and was identified as unstageable, with the wound bed being 100% necrotic tissue. The sheet documented this pressure ulcer was caused by rubbing from the knee immobilizer. The sheet documented the ulcer on the distal left lower leg measured 2.5 x 2 cm, and was identified as unstageable with the wound bed being 100% necrotic tissue. The sheet documented this ulcer was caused by pressure from the knee immobilizer.</p>	F 314	<p>4. The Executive QI committed will meet and review audits to identify and address concerns and/or trends and to follow up as necessary and to determine the frequency and need for continued monitoring weekly X's 4, then monthly X's 3.</p>		

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F 314	<p>Continued From page 22</p> <p>A 09/26/12 physician's progress note documented Resident #3 was being seen for evaluation of an abrasion of her left tibial surface. The physical exam portion of the note documented, "Peripheral pulses are equal in all extremities. No significant varicosities or arterial venous malformations are noted." The assessment portion of the note documented, "Abrasion left tibial surface (secondary to slippage of knee immobilizer)." The plan portion of the note documented, "Knee immobilizer has been stabilized to reduce risk of slippage."</p> <p>At 9:12 AM on 09/27/12 treatment/dressing changes were provided to Resident #3's left lower leg by two treatment nurses. The nurses removed bilateral bunny boots and bilateral immobilizers containing hard rods from the resident's feet and legs. A pressure ulcer four to five inches above the resident's left ankle was 75 % yellow slough and 25% pink tissue, approximately 2 x 3 cm. A pressure ulcer near the resident's left ankle presented as 100% yellow slough with pink edges, approximately 2 x 2 cm. After removal of the old dressings, the ulcers were cleaned with wound cleanser and wet-to-dry dressings were applied. At this time Treatment Nurse (TN) #1 stated the pressure ulcers to Resident #3's left lower leg were the result of an improperly applied immobilizer which had rubbed against the resident's leg. She explained when the immobilizers were applied, the resident's knees were not in the center which caused the immobilizers to bunch toward the bottom of the resident's legs. TN #1 reported that since finding the pressure ulcers on Resident #3's left lower leg, the hall nurses were having to check the resident's immobilizers each shift and</p>	F 314		

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F 314	<p>Continued From page 23 sign off that they were properly applied.</p> <p>At 9:21 AM on 09/28/12 a telephone conversation was held with nursing assistant (NA) #8, who the facility identified as Resident #3's primary NA on first shift. According to NA #8, when staff tried to turn the resident on her sides she complained about pain to her sacrum and legs. She explained the resident would request to be repositioned on her back once again. The NA stated she provided daily bed baths to Resident #3, and was told by nursing that she could remove the immobilizers before the baths and reapply them after the baths. She reported that she was the staff member who actually removed and reapplied the immobilizers. NA #8 commented the facility provided her with no training on how to apply and remove the immobilizers the best she could. She reported that to the best of her knowledge she did not seem to have any problems taking them off or putting them back on. However, she stated the resident did yell and complain of pain when applying and removing the immobilizers. According to NA #8, because of the signs and symptoms of pain, she placed towels inside Resident #3's immobilizers to make them more comfortable until a nurse advised her that the towels would generate too much heat inside closed environments. The NA reported that she found a brown/black area on Resident #3's lower left leg on either Monday, 09/24/12, or Tuesday, 09/25/12. She commented she reported this wound to the hall nurse as soon as she found it.</p> <p>At 11:32 AM on 09/28/12 Resident #3's primary physician stated the resident's diabetes was poorly controlled, the resident was non-compliant</p>	F 314			

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F 314	<p>Continued From page 24</p> <p>with her diabetic diet, and the resident was non-compliant with turning and repositioning.</p> <p>At 3:00 PM on 09/28/12 TN #2 stated Nurse #1 informed the TNs that Resident #3 had pressure ulcers to her left lower leg. According to TN #2, Nurse #1 showed the TNs that the resident's immobilizer was not applied correctly, and was sliding down the resident's left leg. TN #2 reported that it was agreed going forward that the hall nurses had to check the application of the immobilizers after bed baths to make sure they were on the resident's legs correctly.</p> <p>During a telephone interview at 3:24 PM on 09/28/12 Nurse #1 stated she observed two brown/black areas on Resident #3's left lower leg, one near the ankle and the other on the lower leg. This nurse reported she informed the TNs who stated the areas were 100% hard necrotic tissue. She commented she thought the wounds on the resident's left lower leg were caused by the immobilizer sliding down the leg. Nurse #1 stated she thought the bottom part of the immobilizer was rubbing against the leg.</p> <p>At 3:08 PM on 09/28/12 Resident #3's primary physician stated if the resident had PVD, it was very mild. He explained the resident's previous physician documented a diagnosis of PVD because the resident had venous ulcers in the past, but they healed very quickly. The physician reported he had checked the pulses in the resident's feet and ankles, and they were very good for a geriatric resident. However, the physician commented the staff needed to be careful in the application of the immobilizers because they could rub places on the resident's</p>	F 314			

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F 314	<p>Continued From page 25</p> <p>feet and lower legs. According to the physician, scabs did not spontaneously appear. Instead, he explained that wounds progressed from a reddened area which yellowed, thickened, and turned into dark scabs. If a resident's nutrition and health were impaired, the physician commented he had seen scabs develop within a week's time.</p> <p>At 3:14 PM on 09/28/12 Resident #3 stated the leg immobilizers were not comfortable, and they rubbed a place on her leg. She reported she complained they were painful, but was given medicine to keep the pain under control. She stated the NAs took the immobilizers off before baths, and reapplied them afterwards.</p> <p>At 3:18 PM on 09/28/12 NA #9 stated she cared for Resident #3. She reported the resident complained the immobilizers were uncomfortable, but would wear them. She commented she had taken off and reapplied the immobilizers when bathing the resident. According to NA #9, no one in the facility trained her how to apply or remove the immobilizers, but she had worked with other residents over the years that had them, so she felt she could apply and remove them without any problems.</p> <p>At 3:32 PM on 09/28/12 the Director of Nursing (DON) stated the facility did not provide any training to direct care staff about how to apply and remove immobilizers. She reported she was informed the wounds on Resident #3's left lower leg were caused by friction from the immobilizer. However, she commented no staff members had reported to her having problems applying or removing Resident #3's immobilizers. According</p>	F 314		

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F 314	<p>Continued From page 26</p> <p>to the DON, typically wound beds were not found as hard eschar or scabs. She explained pressure ulcers usually started as non-blanchable areas that reddened, opened, and sometimes proceeded to deepen. However, the DON reported she had seen cases with nutritionally compromised residents when this progression from red area to scab occurred in less than a week.</p> <p>At 4:30 PM on 10/05/12 NA #10 stated, during a telephone conversation, she cared for Resident #3 on 09/22/12 and 09/23/12 second shift. She reported although she did not bathe the resident herself on these days, the charge nurse did remove the immobilizers during this time. The NA commented she did not remember seeing any bruising or discoloration to the resident's ankles upon removal. According to the NA, Resident #3 complained about the immobilizers being tight, but she was able to get two fingers under them so she reassured the resident they were okay. She stated she did not notice Resident #3's immobilizers sliding down her legs.</p> <p>At 12:18 PM on 10/09/12 NA #11 stated, during a telephone conversation, she cared for Resident #3 on 09/23/12 when she washed the resident's legs and feet. She explained she had to lift the resident's legs a little in order to wash her feet and heels. NA #11 reported there was yellow bruising on both legs between the knees and the feet. However, she commented she did not see any other skin integrity problems associated with her lower extremities. According to NA #11, Resident #3 did complain some about her ankles hurting and being sore. She also reported the resident complained of the immobilizers being hot</p>	F 314		

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F 314	<p>Continued From page 27</p> <p>and wanting them removed. This NA stated the facility did not provide her with any training about how the immobilizers were to be applied or removed and how they should fit.</p> <p>On 10/10/12 the facility faxed copies of Annual Nurse Assistant Skills Checklists for NA #8 (09/20/11), NA #10 08/04/11), and NA #11 (01/30/12) which documented the NAs were checked off for "Braces, Splints, Prosthesis."</p> <p>At 2:47 PM on 10/10/12, during a telephone conversation, the DON stated the Staff Development Coordinator (SDC) who completed the checklists no longer worked in the facility. However, she reported she had observed this SDC completing the checklists. For each skill on the checklist the DON explained the SDC reviewed the policy and procedure related to it. She stated there was no demonstration or return demonstration involved in completing the skills checklists.</p> <p>b. Labs collected on 06/22/12 documented Resident #3's albumin level was within normal limits, 3.7 grams per deciliter (g/dL) with normal being 3.5 - 5.2 g/dL.</p> <p>A 08/27/12 physician progress note documented, "(Resident #3) appears to be ...well-nourished, well-hydrated ..."</p> <p>A 08/29/12 11:34 AM electronic Resident Progress Note documented Resident #3 was found to have an open blister on her left buttock. The note also documented the wound was cleansed and a dressing was applied.</p>	F 314			

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F 314	<p>Continued From page 28</p> <p>A 09/04/12 Report of Consultation from the orthopedist documented, "Also large decub (decubitus) ulcer left (symbol used) buttock."</p> <p>The resident's 09/05/12 Significant Change Minimum Data Set (MDS) documented her cognition was moderately impaired, she required extensive assistance from two staff members for bed mobility, she did not resist care, and she had one stage II pressure ulcer.</p> <p>In a 09/05/12 Dietary Supplemental Assessment the Dietary Manager (DM) documented Resident #3's meal intake had dropped to 1 - 25% in the last 20 days. According to the assessment, the resident had been receiving a Magic Cup every night for snack and 90 cubic centimeters (cc) of Resource 2.0 three times daily with medication pass. The DM documented the resident's nutritional requirement was 1712 calories daily, with actual intake being only 856 calories daily. The DM also documented, "...Will refer to RD (Registered Dietitian) for consult"</p> <p>At 4:02 PM on 09/27/12 Nurse #2 reported Resident #3 was started on a Magic Cup nightly on 02/07/12, and the resident had been receiving Resource supplement since at least 2009.</p> <p>Review of electronic Resident Progress Notes revealed Resident #3 had not been assessed by the RD (as of 09/28/12 AM).</p> <p>The first documented assessment of Resident #3's buttock/sacral pressure ulcer was on 09/11/12 when an electronic Wound/Ulcer Flow Sheet documented the resident had a stage II</p>	F 314		

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F 314	<p>Continued From page 29</p> <p>buttock/sacral pressure ulcer measuring 6 x 5.5 centimeters (cm) with no depth provided, no exudate, no tunneling/undermining, no odor, and no pain. A wet-to-dry dressing was applied, and the wound bed was 25% yellow/white slough and 75% granulation tissue.</p> <p>On 09/12/12 "Ulceration or interference with structural integrity of layers of skin caused by prolonged pressure related to: incontinence-bowel and/or bladder, immobility, total assistance needed with turning & positioning" and "Actual skin breakdown. Stage 2 to coccyx" were identified as problems on the resident's care plan. Interventions to these problems included, "Monitor skin daily during care for any changes. Report any abnormal observations to nurse" and "Notify appropriate personnel of changes in eating/drinking patterns." Interventions also included, "Weekly assessment of wound/ulcer. Notify physician of changes as indicated."</p> <p>A 09/12/12 physician's progress note did not document any information about the resident's buttock/sacral pressure ulcer. In fact, it documented, "No skin lesions, rashes, jaundice or lymphadenopathy are noted."</p> <p>An electronic 09/17/12 Wound/Ulcer Flow Sheet documented Resident #3's buttock/sacral pressure ulcer was a stage III wound which measured 5 x 4 cm with no depth provided, no exudate, no tunneling/undermining, no odor, and no pain. A wet-to-dry dressing was applied, and the wound bed was 100% yellow/white slough.</p> <p>A 09/21/12 physician's progress note did not</p>	F 314		

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F 314	<p>Continued From page 30</p> <p>document any information about the resident's buttock/sacral pressure ulcer. In fact, it documented, "No skin lesions, rashes, jaundice or lymphadenopathy are noted."</p> <p>An electronic 09/24/12 Wound/Ulcer Flow Sheet documented Resident #3's buttock/sacral pressure ulcer was a stage III wound which measured 4.4 x 4 cm. No other description of the wound was documented.</p> <p>A 09/26/12 physician's order started Resident #3 on vitamin C, zinc sulfate, a multi-vitamin, and protein supplement.</p> <p>A 09/26/12 physician's progress note addressed the wounds to Resident #3's left lower leg, but did not document any information pertaining to the resident's buttock/sacral pressure ulcer.</p> <p>At 9:12 AM on 09/27/12 the Treatment Nurses (TNs) changed the dressing on Resident #3's buttocks/sacrum. There was yellowish drainage on the old dressing which was removed, and a very strong odor was present when this dressing was removed. The wound presented as unstageable with areas of red tissue, yellow slough, and gray slough. The ulcer measured approximately 4 x 4 cm.</p> <p>At 3:50 PM on 09/27/12 TN #2 stated she had only been working as a TN in this facility for about 3 months, but she thought Resident #3 had a history of a sacral pressure ulcer. She reported she thought the ulcer to the resident's buttock/sacrum started as a reddened area, caused in part, by the resident being non-compliant with repositioning on her sides.</p>	F 314		

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F 314	<p>Continued From page 31</p> <p>According to NA #2, the nursing assistants (NAs) were responsible for completing skin checks which were conducted daily as the NAs bathed and showered residents.</p> <p>At 8:37 AM on 09/28/12 the facility's RD stated she was in the facility on 09/21/12, but was not told or notified in writing that she needed to assess Resident #3. However, she commented Resident #3 was on the pressure ulcer list she received before beginning her 09/21/12 assessments.</p> <p>During a telephone conversation at 9:21 AM on 09/28/12 Nursing Assistant (NA) #8, who the facility identified as Resident #3's primary NA on first shift, stated that the resident hollered out and complained of pain during a bed bath sometime between Monday and Thursday following a fall on 08/25/12. When the NA examined the resident, she reported she found the skin had been rubbed off the resident's sacrum. She stated TN #2 placed a Tegaderm on the resident's sacrum. 1 to 2 weeks later NA #8 reported the Treatment NA was going to only put cream on the area, and she told the Treatment NA that the resident had open areas to the sacrum. When the Treatment NA and NA #8 observed the area, NA #8 commented the wound was completely yellow.</p> <p>At 9:47 AM on 09/28/12 TN #2 stated Resident #3's primary physician had signed off on the facility's 09/13/12 Quality Improvement (QI) wound list. However, she reported he had not signed off on the facility's 09/20/12 QI wound list although it was completed. She stated the only medical doctor (MD) communication form sent to Resident #3's physician, concerning her</p>	F 314			

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F 314	<p>Continued From page 32</p> <p>buttocks/sacral pressure ulcer was on 08/29/12 when a nurse documented the resident had an open blister on her left buttock.</p> <p>At 10:25 AM on 09/28/12 the facility's RD stated the facility identified the communication between the DM and RD as a problem 45 - 60 days ago, and it was handled internally, but not run through the facility's QI program. She commented the problem was the DM was documenting referrals in the computer, but not relaying them to the RD on paper so RD assessments could be completed.</p> <p>At 11:32 AM on 09/28/12 Resident #3's primary physician stated he thought he had observed and assessed the resident's buttocks/sacral pressure ulcer, but was not absolutely certain. He stated he thought he heard that this wound would get better and then decline. This physician commented the facility often referred residents with pressure sores out to another physician who specialized in wound assessment, but was not sure if this was done for Resident #3. He stated he did not remember the resident's buttock/sacral pressure ulcer starting out as a blister, but thought it was due to refusal of turning and repositioning in the bed. According to Resident #3's physician, wounds with slough did not usually appear spontaneously, but started out as open reddened areas that declined.</p> <p>At 11:48 AM on 09/28/12 the Treatment NA stated usually hall NAs would tell her about skin changes, and she would write them down so she could observe them. However, she reported she could not find any written record which she made of Resident #3's buttocks/sacral area. According</p>	F 314			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/28/2012
NAME OF PROVIDER OR SUPPLIER ROANOKE RIVER NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 119 GATLING STREET WILLIAMSTON, NC 27892		
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F 314	<p>Continued From page 33</p> <p>to the Treatment NA, she remembered finding skin off the resident's sacrum, and a TN applied a Tegaderm to be changed every 7 days. She stated she observed Resident #3's buttocks/sacral pressure ulcer again on 09/11/12 when the dressing was changed to wet-to-dry daily. At that time, the Treatment NA remembered there being odor to the wound, the wound was deeper, and about 25% of the wound was covered with yellow slough.</p> <p>At 12:22 PM on 09/28/12 TN #2 stated, according to the facility's Treatment Administration Record (TAR), Resident #3 had a transparent dressing placed on an open blister on 08/29/12. Then on 08/30/12 and 08/31/12 a Tegaderm dressing was placed on the buttocks/sacral pressure ulcer. On 09/04/12 TN #2 reported a hydrocolloid dressing was placed on the ulcer, and replaced with the same type of dressing on 09/05/12 because of rolling up. According to TN #2, she thought she remembered looking at Resident #3's buttocks/sacral ulcer on 09/04/12, and the wound bed was red with no slough. TN #2 commented she did not document any measurements of descriptions of this ulcer until 09/11/12 when the dressing was changed to a daily wet-to-dry. She commented because of the decline in the buttocks/sacral ulcer and the emergence of wound odor she placed a call to the corporate wound consultant today (09/28/12).</p> <p>At 3:32 PM on 09/28/12 the Director of Nursing (DON) stated it was facility policy to measure and assess pressure ulcers weekly on the electronic Wound/Ulcer Flow Sheets. She reported that Resident #3 had not been referred outside of the facility for wound consults. She commented skin</p>	F 314			

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F 314	Continued From page 34 checks were completed by the NAs as they provided daily baths and showers. The DON explained the NAs reported skin integrity problems to the hall nurses who then contacted the TNs.	F 314			