STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING _____ B. WING _____ DEC 14 2012	C 11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUGH CHATHAM MEMORIAL NURSING	700 JOHNSON RIDGE RD ELKIN, NC 28621

(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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to notify the resident ' s responsible	F 157	The action included in the plan of correction is not an admission of deficient practice, but is completed to satisfy state and federal regulations. 1.) The interdisciplinary care plan team met with resident #4's responsible party on November 27, 2012 at 11:00am to review the resident's current plan of care, her current medical condition that included the pressure ulcer and any other concern /condition that the family may have not been aware of. 2.) All resident with wounds were reviewed by Director of Nursing and Nurse Consultant to ensure that all residents, physicians and / or responsible parties had been notified of any wound and / or significant changes in the wound that may require a new or altered treatment.. Any incidents where proper notification was not documented, the responsible party and/or physician was contacted	11/27/12 12/10/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ramsay B Smith | TITLE: Administrator | (X6) DATE: 12/12/12

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.

P.B

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F 157	Continued From page 1 party when a pressure sore developed on the left buttock which progressed to an advanced pressure sore (Stage 4). This was evident for 1 of 3 residents whose records were reviewed for responsible party notification. (Resident#4) Findings included: The policy and procedure for notification revealed the policy was entitled " Acute Incident Episode Protocol, dated 1993 and revised 1/10. Policy: 1. Acute incident/episode is defined as a new onset or occurrence indicating a change in mental, physical, emotional status or a combination of signs and symptoms which indicate a needed change in treatment or medication regime. 2. Examples of Acute Episode (Not all inclusive) " i. Skin tears/problems " Procedure: #4 Notify family (Responsible Party) and document name of person to whom you have spoken. Resident#4 had cummulative diagnoses which included; Cerebral Arterial occlusion, Late effect CVA. Review of the MDS (Minimum Data Set) dated 5/4/12 revealed the resident was dependent on staff for all activities of daily living and was moderately impaired. Review of the nurses notes dated 6/30/12 revealed the NA #1 (Nursing Assistant) was giving perineal care to Resident#4. NA#1 turned Resident#4 and noted a stage 2 pressure sore (ps) on her buttock. A stage 2 ps was defined as a partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. NA#1 notified	F 157	3a.) All nursing staff has been properly in-serviced by the SDC and/or designee to notify the resident, responsible party and/or physician according to facility policy. All staff in-services will be completed by December 21, 2012. 3b.)A process was developed to record wound and other skin issues on a log weekly. Recorded on the log, is the date, the family/MD was notified. This information is reviewed and discussed weekly in the Wound, Weight, Fall Committee Meeting. This log will continue to be reviewed at the weekly Wound, Weight, Fall Committee Meetings. At this weekly meeting, this log will be reviewed for continued compliance. If any problems would be identified they are to be immediately reported to the DON or Administrator or designee for prompt resolution. 4.) The facility will continue to monitor proper notification of this practice with The Family / Physician Notification Log. This log will require that all nurses document every incident, significant change, etc., onto this log daily to ensure timely notification. This log will be monitored daily by the DON, Administrator or designee until January 10, 2013 to ensure compliance. Once compliance has been established, the log will then be monitored at the weekly falls/wounds/weight loss meetings. At this weekly meeting, the log will be reviewed for continued compliance. The Family / Physician Notification Log will also be reviewed at the facility's Monthly PI Meetings for further monitoring of compliance. The next PI Meeting will be held no later than January 29, 2013.	12/21/12 01/10/13 Ongoing 01/10/13 Ongoing

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F 157	Continued From page 2 Nurse #1. The ps measured 5 cm (centimeters) x 3.5 cm with irregular edges with bleeding noted. Review of the nurses notes dated 7/4/12 revealed Nurse #2 indicated the wound measured 6cm x 3cm with no measurable depth. The wound bed was 50% white slough with a 0.25cm x 0.25 cm area of eschar in central part of wound. The surrounding area was excoriated with erythema. A phone interview on 11/29/12 at 3:15 pm with Nurse#1 revealed the ps was not a new pressure ulcer as it was already there but had worsened. She stated she faxed a note to the wound Dr. Soos that morning. " I work 3rd shift so I don ' t usually see the Doctor. I was told he came in 1 or 2 days later and evaluated the resident with the family there. " There was no documentation stating the physician was faxed a note or that the Supervisor was notified. An interview with the administrator on 11/29/12 at 4:00 pm revealed she did not have documentation that the RP was notified of the pressure ulcer worsening or the pressure ulcer was on the buttock. A phone interview on 11/29/12 at 5:20 pm with Nurse #2 revealed she works nights and would not call the RP as she would report the change (worsening) to the on-coming nurse and it would be the Supervisor who would notify the RP. A phone interview on 11/29/12 at 12:06 pm with NA#1 revealed she reported the pressure sore to the nurse and did not know if the nurse reported the information to the family member. A phone interview for NA#2 on 11/29/12 at 12:07 pm was attempted. A message was left to return the call. Review of the nurses ' notes from 6/30/12 (the initial date the pressure sore was noted) through 11/19/12 revealed there was no documentation found to indicate the responsible party was	F 157		

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

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F 157	Continued From page 3 notified of the pressure sore when it was initially discovered and no documentation that the responsible party was notified that the ps worsened. A phone interview was conducted with the resident ' s family member on 11/19/12 at 3:15 PM that revealed " I wasn ' t told anything. No one called and no one told me about the new pressure sore (discovered on 6/30/12). " An interview with the Administrator and Director of Nurses (DON) was conducted on 11/19/12 at 5:00 PM. The administrator revealed " I know we had an incident report with a space where the notification of the RP is checked but we cannot find it, and I cannot find it in the nurses notes. " An interview with the facility Administrator was conducted on 11/19/12 at 6:00 PM revealed her expectation of her staff was to notify the responsible Party or legal Respresentative of the resident ' s change in condition and treatments.	F 157		