STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345126	A. BUILDING _____ B. WING _____	C 10/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVE CENTER	228 SMITH CHAPEL RD BOX 569 MOUNT OLIVE, NC 28365

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F 157 SS=B	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, staff and family interviews, the facility failed to notify a resident ' s power of attorney of changes in the resident ' s	F 157	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Mount Olive Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." **F-157** 1. The center transported resident #3 to her routine dialysis appointment on 9/23/13. Davita Dialysis Center, Mount Olive notified the facility that the resident had been a direct admission to the hospital from dialysis. 2. The medical records of other residents were reviewed between 10/17/13 and 10/23/13 by the Nursing Supervisor to ensure that any change of condition had been communicated to the residents Health Care Power of Attorney (HCPA) or responsible party. The initial audit revealed one late notification that was immediately corrected. Medical records were also reviewed by the Social Worker to ensure that the contact information for HCPA or responsible party was on the resident profile.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Will J Mercer | TITLE: Administrator | (X6) DATE: 10/25/13

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 157	Continued From page 1 condition for 1 (Resident #3) of 3 sampled residents reviewed for changes in condition. The findings included: Resident #3 was admitted to the facility from the hospital on 08/16/13 with diagnoses that included End Stage Renal Disease on Hemodialysis, Recurrent UTI, Hypertension, Diabetes, Anemia of Chronic Kidney Disease, Sacral Decubitus Ulcer and Dementia. There was a form on the resident ' s medical record showing that the resident had designated a specific family member as her health care power of attorney. A nursing admission note dated 8/16/13 at 8:00 PM revealed that the resident had been admitted to the facility from the hospital earlier in the evening after being treated in the hospital for urosepsis. The admission note revealed that the resident was alert but very confused with short term memory deficits. The note revealed that the resident knew her name but was unable to recall the time, date, year or place. The note revealed that upon examination the resident had an approximately 4 centimeter (cm) by 3 cm Stage 3 decubitus ulcer to the coccyx area. There was no description of the area documented in the nurse ' s note. The note revealed that both of the resident ' s heels were dry with some redness noted, the right being greater than the left. A Skin Integrity Report dated 8/16/13 revealed that the resident was admitted with an unstageable pressure ulcer on the sacrum. An unstageable pressure ulcer is characterized by full thickness tissue loss in which the actual depth	F 157	Records for current residents were reviewed and were found to contain contact information. The accuracy of current information is being verified by Social Services. 3. The licensed nurses were reeducated on the process of notification of change of condition including the responsible party on 10/17/13, 10/18/13, 10/21/13 and 10/23/13 by SDC. Training is continuing to assure current staff has been re-educated. The Social Workers and Admissions were reeducated on ensuring that HCPA and/or responsible party contact information is current and on the resident's profile by DON on 10/15/13. An audit of medical record will be completed to assure that the HCPA and or responsible party have been notified of any change of condition by the Administrative Nurses 5 days a week for one month, then weekly for 2 months. An audit of the resident's profile will be conducted monthly for 3 months ensure that there has been no change in contact information for the resident. This audit will be conducted by the Social Workers.	

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F 157	Continued From page 2 of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown, or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth of the wound cannot be determined but would be a Stage 3 or Stage 4. A nurse ' s note dated 8/17/13 7-3 (7AM-3PM shift) revealed that the resident was alert and verbal with baseline confusion. The Skin Integrity Report dated 8/21/13 revealed that the unstageable pressure ulcer on the resident ' s sacral area was over 75% necrotic and measured 9cm by 12cm. A nurse ' s note dated 8/21/13 3-11 (3PM-11PM shift) revealed that the resident was confused at times. The note revealed that the POA visited the resident that evening and discussed the resident ' s diabetes with the nurse. There was no documentation in the nurse ' s notes that the POA was advised of the condition of the resident ' s pressure ulcer. An Interdisciplinary Progress note dated 8/22/13 at 3:50 PM revealed that the Interdisciplinary Team (IDT) reviewed the resident for admission, antibiotics and wounds. The note revealed that the resident had a large 9 by 12cm unstageable area to the sacrum with 100% brown eschar covering the wound bed. The note revealed that the wound was being treated with a topical medication that continuously removes necrotic tissue allowing new, healthy tissue to form. The note revealed that the resident was taking an antibiotic for a wound infection and that the physician had ordered a wound clinic consult. A	F 157	4. The Director of Nurse will analyze the audits for notification of HCPA and residents profile for any pattern/trends and report to QAPI monthly for 90 days. 5. Completion Date:	10/25/13

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F 157	Continued From page 3 review of the nursing progress notes revealed no documentation that the resident ' s Power of Attorney (POA) was notified of the wound treatment, infection or of the wound clinic consult. A nurse ' s note dated 8/22/13 at 10:00 PM noted an upcoming appointment with the wound clinic and that the resident was on an antibiotic for a wound infection. The note revealed that family was in to visit. There was no documentation that the POA was notified of the resident ' s condition. A nurse ' s note dated 8/28/13 at 7:50 PM revealed that the resident was alert and confused. A nurse ' s note dated 8/29/13 7-3 revealed that a new area was noted to the left ankle. There was no documentation that the resident ' s POA was notified of the new areas. A nurse ' s note dated 8/29/13 at 3:35 PM revealed that the Interdisciplinary Team reviewed the resident wounds noting that the unstageable area to the sacrum could not be staged due to greater than 75% eschar/necrosis covering the wound bed. The entry noted 2 new suspected deep tissue injury areas to the left outer heel and left ankle. There was no documentation that the resident ' s POA had been notified of the new areas. A nurse ' s note dated 9/1/13 at 9:20 PM revealed that the resident was alert with baseline confusion. The Skin Integrity Report dated 8/29/13 revealed that the resident ' s left heel had an area of suspected deep tissue injury that measured	F 157		

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F 157	Continued From page 4	F 157		

2.5cm by 3.5cm. The report also revealed that on 8/29/13 the resident had a suspected deep tissue injury to the left ankle that measured 1.7cm by 1.3cm. The National Pressure Ulcer Advisory Panel under NPUAP Pressure Ulcer Stages/Categories advises that suspected deep tissue injury (SDTI) is a purple or maroon localized area of discolored intact skin or blood-filled blister due to underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy or boggy. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment. There was no documentation in the nurse ' s notes that the resident ' s POA had been notified of the changes in the resident ' s heel and ankle.

A nurse ' s note dated 9/10/13 7-3 revealed that the resident was alert with baseline confusion.

A nurse ' s note dated 9/18/13 revealed that the resident had confusion at intervals to time and place.

Weekly wound assessments on the Skin Integrity Report revealed that the sacral wound remained unstageable until 9/22/13 when the wound was documented as a Stage IV pressure ulcer. A Stage IV pressure ulcer is characterized by full thickness loss with exposed bone, tendon or muscle. Slough or eschar may be present but does not obscure the depth of tissue loss. There was no documentation in the resident ' s medical record that the POA was notified of this change.

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F 157	Continued From page 5 Nurse ' s notes dated 9/23/13 revealed that Resident #9 went to dialysis and was sent to the hospital from dialysis for altered mental status. A review of the facility ' s Grievance Log revealed a grievance dated 9/23/13 at 5:45 PM that the POA called the facility and stated that the hospital told him that the resident had a real bad, bad, bad bed sore and that he thought the facility was taking better care of his family member than that. On 10/14/13 at 2:14 PM the Unit Manager stated in an interview that Resident #9 was listed on the face sheet as her own responsible party. On 10/14/13 at 6:10 PM the Director of Nursing (DON) stated in an interview that if a resident was her own responsible party (RP), the staff would not have notified the family of any changes in condition. The DON stated that staff would notify the RP of changes in condition such as confusion, infections, new wounds, weight loss or behaviors. The DON stated that the responsible party was determined upon admission by the social worker. The Social Worker stated in an interview on 10/14/13 at 6:20 PM that on admission if a family member says they are the POA and do not have a copy of the form, she asks for a copy of the form. The Social Worker stated that a family member was the POA for Resident #9 and provided a form that was on the resident ' s medical record. The Social Worker stated that the POA for Resident #9 attended the 72 hour post admission conference that included the social worker, rehab services, nursing, business office staff and activities.	F 157		

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F 157	Continued From page 6 On 10/14/13 at 6:35 PM an interview was conducted with the DON and the Unit Manager. The Unit Manager stated that the resident was listed on the face sheet as her own RP and did not notify the family of changes in the residents wound or wound treatments. The Unit Manager stated that the nurses referred to the face sheet to determine the responsible party or the POA. The DON stated that the nurses were supposed to document notification of the POA with any changes in condition. The DON was observed to review the nurse ' s notes for Resident #9 and stated that she did not see any documentation that the resident ' s POA was notified of changes in her condition. On 10/15/13 2:20 PM an interview was conducted with the resident ' s health care power of attorney. The POA Stated that he and another family member visited the resident every day and they were never told anything about the wound. The POA stated that when the resident went to the hospital from dialysis the smell was terrible. The POA stated that he was not told that the resident was on antibiotics for a wound infection or that an appointment had been scheduled with the wound clinic. The POA stated that when the resident was admitted to the facility, she did not have any pressure sores. The POA stated that he would ask the staff how the resident was doing and all they ever told him was that she was not eating.	F 157		