

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

JAN 28 2014

PRINTED: 01/17/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345329	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 01/03/2014
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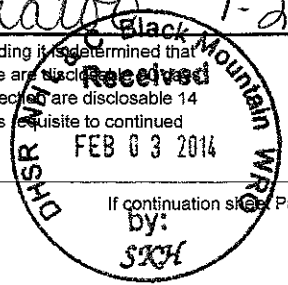
NAME OF PROVIDER OR SUPPLIER  GATEWAY REHABILITATION AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2030 HARPER AVE NW LENOIR, NC 28645
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 157 SS=B	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>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).</p> <p>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.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and family and staff interviews the facility failed to notify a resident's interested family/responsible party of a new stage</p>	F 157	<p>This Plan of Correction does not constitute an admission or agreement by provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and federal law.</p> <p><b>F157</b></p> <ol style="list-style-type: none"> <li>Resident # 1 no longer resides at the facility.</li> <li>All residents have the potential to be affected by this citation. A review of residents' charts for notification for change in condition will be completed by 1/28/14 by the Director of Clinical Services, Assistant Director of Clinical Services, Nurse Manager.</li> <li>Licensed Nurses were inserviced by the Director of Clinical Services, Assistant Director of Clinical Services and/or Nurse Manager on notifying responsible party and physician of significant changes in resident condition 1/6/14-1/28/14.</li> </ol>	1/31/14
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Getta Madsen* TITLE: Administrator (X6) DATE: 1-24-14

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 14 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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NAME OF PROVIDER OR SUPPLIER  <b>GATEWAY REHABILITATION AND HEALTHCARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2030 HARPER AVE NW</b> <b>LENOIR, NC 28645</b>	
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F 157	<p>Continued From page 1</p> <p>II pressure ulcer in 1 of 3 sampled residents who had developed pressures ulcers in the facility. (Resident #1).</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on 02/29/12 with diagnoses which included diabetes and a history of pressure ulcers on sacrum (area of skin over the tailbone). A review of the most recent annual Minimum Data Set (MDS) dated 12/09/13 indicated Resident #1 had short term and long term memory problems and was severely impaired in cognition for daily decision making.</p> <p>A review of a facility document titled "Weekly Skin Integrity Review" indicated Resident #1 had redness on her buttocks documented on 12/09/13.</p> <p>A review of a physician's order dated 12/14/13 indicated Hydrocolloid dressing (a clear, waterproof dressing to absorb wound drainage) to open area on buttocks and open area on upper thigh. Change dressing every 3 days and as needed. Check placement of dressing every shift and monitor for pain before, during and after dressing change.</p> <p>A review of nurse's notes dated 12/14/13 indicated there was no documentation of notification to family/responsible party regarding the open area of skin on Resident #1's buttocks and thigh.</p> <p>During a telephone interview with a family member on 01/02/14 at 10:15 AM she explained family members visited with Resident #1 in the</p>	F 157	<p>The Director of Clinical Services, Assistant Director of Clinical Services and/or Nursing Manager will conduct Quality Improvement monitoring of 10 resident charts for notification of changes five times a week for one month, three times a week for two months, two times a week for one month and one time a week for 1 month.</p> <p>4. The results of the QI monitoring will be reported by the Director of Clinical Services/Assistant Director of Clinical Services to the Quality Assurance Performance Improvement Committee for 6 months and/or until substantial compliance is obtained.</p>	

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F 157	Continued From page 4 physicians order dated 12/14/13 due to a wound on her buttocks but he could not find documentation in the nurses notes that the family/responsible party was notified. He further stated a new wound was considered to be a change in condition and the family/responsible party should have been notified.  During an interview on 01/03/14 at 5:12 PM the Director of Nursing (DON) stated it was her expectation that notification of the family/responsible party should occur immediately and the notification should be documented in the nurses notes or on a change in condition form. She further stated she was not aware the family/responsible party had not been notified about Resident #1's stage II pressure ulcer on her buttocks.	F 157			
F 309 SS=D	<b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to assess a new stage 2 pressure ulcer and failed to implement treatment to a heel wound in 2 of 3 residents who had developed pressure ulcers. (Resident #1 and #4).	F 309	<b>F309</b>  1. Resident # 1 no longer resides at the facility. Resident #4's pressure area was assessed by a licensed nurse and treatment implemented on 12/24/13.  2. All residents have the potential to be affected by this citation. A review of resident's skin integrity was	1/31/14	

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F 309	<p>Continued From page 5</p> <p>The findings included:</p> <p>1. Resident #1 was admitted to the facility on 02/29/12 with diagnoses which included diabetes and a history of pressure ulcers on sacrum (area of skin over the tailbone). A review of the most recent annual Minimum Data Set (MDS) dated 12/09/13 indicated Resident #1 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS further indicated Resident #1 required extensive assistance by staff for activities of daily living and was at risk for developing pressure ulcers.</p> <p>A review of a facility document titled "Weekly Skin Integrity Review" indicated Resident #1 had redness on her buttocks documented on 12/09/13.</p> <p>A review of a Care Area Assessment dated 12/09/13 indicated Resident #1 was at risk for pressure ulcers due to incontinent episodes and decreased independence with mobility. The notes further indicated staff should turn and position Resident #1 approximately every 2 hours as well as perform weekly skin sweeps to assess skin integrity.</p> <p>A review of a physician's order dated 12/14/13 indicated Hydrocolloid dressing (a clear, waterproof dressing to absorb wound drainage) to open area on buttocks and open area on upper thigh. Change dressing every 3 days and as needed. Check placement of dressing every shift and monitor for pain before, during and after dressing change.</p> <p>A review of nurse's notes dated 12/14/13</p>	F 309	<p>completed between 1/20/14 to 1/25/14 by the Director of Clinical Services, Assistant Director of Clinical Services, Nurse Manager.</p> <p>3- Licensed Nurses will be in-serviced by the Director of Clinical Services, Assistant Director of Clinical Services and/or Nurse Manager by 1/28/14 on assessing resident's skin integrity and implementing physician orders as appropriate and transcribing of physician orders timely. The Director of Clinical Services, Assistant Director of Clinical Services and/or Nursing Manager will conduct Quality Improvement monitoring of 10 resident skin</p>	

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F 309	<p>Continued From page 6</p> <p>indicated there was no nursing assessment regarding the size or appearance of the pressure ulcer on Resident #1's buttocks or upper thigh.</p> <p>A review of medical records revealed there was no S (situation) B (background) A (assessment/appearance) R(request) Communication Form with documentation of the assessment for the new wound on Resident #1's buttocks or thigh on 12/14/13.</p> <p>During an interview on 01/02/14 at 3:31 PM Nurse #4 stated he worked Monday through Friday on the 7:00 AM to 3:00 PM shift and Resident #1 had a new open area of skin on her buttocks that was a Stage 2 pressure ulcer. He stated Resident #1 had the stage 2 pressure ulcer before she went to the hospital on Sunday 12/15/13 but he was not sure when it had occurred because he had not assessed it. He stated the Weekly Skin Integrity Review Sheet was the weekly skin sweep and if a wound occurred after the weekly skin sweep was done then an assessment should have been documented in the nurses notes.</p> <p>During an interview on 01/02/14 at 4:06 PM the Wound Care Nurse stated she did measurements on pressure ulcers on Monday of each week and the weekly skin sweeps were filled out by the nurses. She explained skin sweeps were scheduled for residents on different days of the week and verified before Resident #1 went to the hospital on 12/15/13 her weekly skin assessments were to be done on Monday on the 7:00 AM to 3:00 PM shift. She explained she checked all wound documentation on Mondays but due to her work schedule if a wound occurred after Wednesday she would not see the</p>	F 309	<p>integrity assessments and their charts for proper assessment of skin, implementation of physician order and transcription of the physician order five times a week for one month, three times a week for two months, two times a week for one month and one time a week for 1 month.</p> <p>4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services/Assistant Director of Clinical Services for 6 months and/or until substantial compliance is obtained.</p>	

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F 309	<p>Continued From page 7</p> <p>documentation until Monday of the following week and she relied on the nurses to document their assessments of wounds in the nurses notes.</p> <p>During a telephone interview on 01/03/14 at 8:23 AM Nurse #5 explained she did not remember what she had been told about Resident #1's wound on her buttocks during the 7:00 AM shift report on 12/14/13. She stated a Nursing Assistant (NA) had reported to her sometime after 7:00 AM on 12/14/13 that she needed to check Resident #1's skin on her buttocks. Nurse #5 explained she changed Resident #1's dressing on her buttocks and remembered the wound looked different than it had from when she had worked the previous weekend. She stated she could not remember her assessment of the wound on Resident #1's buttocks or thigh but should have documented her assessment of the wounds in the nurse's notes. She further stated if there was no documentation of assessments of the wounds then she must have overlooked it.</p> <p>During a telephone interview on 01/03/14 at 9:02 AM the weekend Nursing Supervisor stated nothing was reported to her on 12/14/13 regarding a new wound on Resident #1's buttocks. She explained on Sunday 12/15/13 she was told that a NA had alerted a nurse to look at Resident #1's bottom because there was an open wound. She further stated she did not remember that Resident #1 had any open areas of skin on her bottom when she had last worked on the weekend before. She explained she checked Resident #1's buttocks on Sunday 12/15/13 and saw new areas of open skin on each buttock with drainage that looked like they needed immediate attention. She stated she had never known for Resident #1's skin on her bottom</p>	F 309			

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F 309	<p>Continued From page 8</p> <p>to break down like that. She stated Nurse #5 was assigned to care for Resident #1 and should have assessed the open wound on her buttocks and should have documented it in the nurse's notes or on the SBAR Communication Form.</p> <p>During an interview on 01/03/14 at 3:17 PM the Assistant Director of Nursing (ADON) stated he expected to see a nursing assessment documented by Nurse #5 since she was assigned to care for Resident #1 on 12/14/13 that included a description of the open wounds, size and any drainage of the wounds. He stated nurses were expected to complete a SBAR Communication Form anytime a resident had a change in condition and a new open wound was considered to be a change in condition. He further stated nursing staff should have documented assessment findings as soon as the new wounds were identified.</p> <p>During an interview on 01/03/14 at 5:12 PM the Director of Nursing (DON) stated it was her expectation for nurses to assess a resident's skin condition and should document their assessment findings. She further stated when a resident had a new wound it should be documented as soon as it was identified on the SBAR Communication Form so the condition of the wound could be monitored.</p> <p>2. Resident # 4 was readmitted to the facility 07/24/13 after hospitalization 07/21/13-07/24/13 for pneumonia. Original admitting diagnoses included cerebrovascular accident, hypertension, atrial fibrillation, hypothyroidism, dementia, rheumatoid arthritis and delirium.</p> <p>Review of the current care plan for Resident #4</p>	F 309			

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F 309	<p>Continued From page 9</p> <p>noted the following problem areas and approaches: 06/12/13-Potential or actual skin breakdown related to recent fall with facial laceration resulting in surgical repair, rib fractures, decreased mobility and weakness. -skin assessments at least weekly -treatments per order 06/12/13-Requires assistance with activities of daily living (ADLs) related to recent history of falls, decreased mobility, difficulty walking, muscle weakness. -monitor weekly skin sweeps</p> <p>Review of physician orders in the medical record of Resident #4 noted an order written by the facility treatment nurse on 12/20/13 which included: 1. Heel up device while in bed. Check placement every shift. 2. Skin prep to area on left heel three times a day until healed. Monitor pain before, during and after application. On 12/24/13 at 11:00 PM another physician's order was written for, Skin prep to left heel twice a day. Monitor for pain during and after.</p> <p>Review of the December 2013 treatment record for Resident #4 noted the skin prep was not transcribed and implemented until 12/24/13 on the 03:00 PM-11:00 PM shift.</p> <p>On 01/02/14 at 4:10 PM the facility treatment nurse stated as best she could recall on 12/20/13 she was looking at a skin tear on the left lower leg of Resident #4 and noted the concern on his left heel. The treatment nurse stated she remembered telling the nurse of Resident #4 about the concern and wrote the order for skin</p>	F 309			



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F 309	<p>Continued From page 10</p> <p>prep on his left heel three times a day. The treatment nurse stated she could not recall which nurse she reported the concern to. The treatment nurse stated she usually processed orders but, if there were time limitations, she would have left it for the nurse to process. The treatment nurse stated she could not recall the circumstances of the 12/20/13 order for skin prep but if she was not able to process the order she would have assumed the nurses would have written it on the treatment record. The treatment nurse verified the order for skin prep was not transcribed on the treatment record until 12/24/13 and could offer no explanation for the omission. The treatment nurse stated her practice was to measure all wounds on Mondays so the first documentation of measurements of the wound was 12/23/13. Review of the Pressure Ulcer Record for Resident #4 noted on 12/23/13 the area on the left heel was assessed as 4 X 6 with red/black eschar.</p> <p>On 01/03/14 at 9:45 AM Nurse #6 stated when doing the weekly skin assessment on 12/24/13 he noticed the area on the left heel of Resident #4. Nurse #6 stated he looked in the medical record of Resident #4 and noted the 12/20/13 order for skin prep had not been transcribed on the treatment record. Nurse #6 stated he called the physician of Resident #4 for clarification and wrote the order for skin prep again on 12/24/13. Nurse #6 stated he could not explain why the 12/20/13 order for skin prep had not been implemented as ordered.</p> <p>On 01/03/14 at 5:15 PM the facility Director of Nursing (DON) stated she would have expected all orders to be properly transcribed and followed in a timely manner. The DON could not explain</p>	F 309			

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F 309	Continued From page 11 the five day delay in initiation of skin prep to the left heel ulcer of Resident #4.	F 309			
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to complete nursing documentation for skin assessments, change in condition forms and medication administration records for 3 of 3 residents with pressure sores (Resident # 1, #4 and #3).  The findings included:  1. Resident #1 was admitted to the facility on 02/29/12 with diagnoses which included diabetes and a history of pressure ulcers on sacrum (area of skin over the tailbone). A review of the most recent annual Minimum Data Set (MDS) dated 12/09/13 indicated Resident #1 had short term and long term memory problems and was	F 514	<b>F514</b>  1. Resident # 1 no longer resides at the facility. Resident # 4 skin integrity review, treatment record signed and weekly progress note were completed on 1/14/14 by a licensed nurse. Resident #3 skin integrity review, and weekly progress note were completed on 1/11/14 by a licensed nurse.  2. All residents have the potential to be affected by this citation. A review of resident's skin integrity, treatment and medication record and weekly progress notes will be completed between 1/20/14 to 1/28/14 by the Director of Clinical Services, nurse manager.  3. Licensed Nurses will be in-serviced by the Director of Clinical Services, Assistant Director of Clinical Services and/or Nurse	1/31/14	

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NAME OF PROVIDER OR SUPPLIER  <b>GATEWAY REHABILITATION AND HEALTHCARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2030 HARPER AVE NW</b> <b>LENOIR, NC 28645</b>		
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F 514	<p>Continued From page 12</p> <p>severely impaired in cognition for daily decision making. The MDS further indicated Resident #1 required extensive assistance by staff for activities of daily living and was at risk for developing pressure ulcers.</p> <p>A review of a physician's order dated 01/11/13 indicated Novolog Flexpen insulin for sliding scale insulin coverage before meals daily at 6:30 AM; 11:30 AM; 4:30 PM and at bedtime at 8:00 PM as follows: 150-200=2 units subcutaneously (SQ) 201-250=4 units SQ 251-300=6 units SQ 301-350=8 units SQ 351-400=10 units SQ Greater than 400 - notify physician</p> <p>A review of a physician's order dated 07/12/13 indicated Levemir Flexpen insulin 12 units SQ twice daily at 8:00 AM and 8:00 PM.</p> <p>A review of a monthly Medication Administration Record (MAR) dated October 2013 indicated there was a blank space on the following date: 10/27/13 at 8:00 PM there was no documentation of a blood glucose or insulin coverage given. There was no explanation documented on the back of the MAR.</p> <p>A review of a monthly MAR dated November 2013 indicated there were blank spaces on the following dates: 11/20/13 at 4:30 PM there was no documentation of a blood glucose or sliding scale insulin coverage given. There was no explanation documented on the back of the MAR. 11/22/13 at 8:00 AM there was no documentation of the 8:00 AM Levemir Flexpen insulin. There</p>	F 514	<p>Manager on assessing resident's skin integrity, signing treatment and medication record and completing weekly progress note accurately by 1/28/14.</p> <p>The Director of Clinical Services, Assistant Director of Clinical Services and/or Nursing Manager will conduct Quality Improvement monitoring of 10 resident's charts for completion of the skin integrity assessments, treatment and medication records and weekly progress notes five times a week for one month, three times a week for two months, two times a week for one month and one time a week for 1 month.</p> <p>4. The results of QI monitoring will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services/Assistant Director of Clinical Services for 6 months and/or until substantial compliance is obtained.</p>		

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F 514	<p>Continued From page 13</p> <p>was no explanation documented on the back of the MAR.</p> <p>11/22/13 at 8:00 PM there was no documentation of a blood glucose or sliding scale insulin coverage given. There was no explanation documented on the back of the MAR.</p> <p>11/24/13 at 8:00 PM there was no documentation of a blood glucose or sliding scale insulin coverage given. There was no explanation documented on the back of the MAR.</p> <p>11/30/13 at 4:30 PM there was no documentation of a blood glucose or sliding scale insulin coverage given. There was no explanation documented on the back of the MAR.</p> <p>A review of a monthly MAR dated December 2013 indicated there were blank spaces on the following dates:</p> <p>12/10/13 at 8:00 PM there was no documentation of a blood glucose or sliding scale insulin coverage given. There was no explanation documented on the back of the MAR.</p> <p>12/11/13 at 8:00 PM there was no documentation of the 8:00 PM Levemir Flexpen insulin. There was no explanation documented on the back of the MAR.</p> <p>12/11/13 at 8:00 PM there was no documentation of a blood glucose or sliding scale insulin coverage given. There was no explanation documented on the back of the MAR.</p> <p>12/12/13 at 8:00 PM there was no documentation of the 8:00 PM Levemir Flexpen insulin. There was no explanation documented on the back of the MAR.</p> <p>A review of a physician's order dated 12/14/13 indicated Hydrocolloid dressing (a clear, waterproof dressing to absorb wound drainage) to open area on buttocks and open area on upper</p>	F 514			

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F 514	<p>Continued From page 14</p> <p>thigh. Change dressing every 3 days and as needed. Check placement of dressing every shift and monitor for pain before, during and after dressing change.</p> <p>A review of a nurse's note dated 12/14/13 indicated there was no documentation regarding size or appearance of the pressure ulcer on Resident #1's buttocks or upper thigh.</p> <p>A review of medical records revealed there was no S (situation) B (background) A (assessment/appearance) R(request) Communication Form for the new wound on Resident #1's buttocks or thigh dated 12/14/13.</p> <p>A review of a facility document titled SBAR Communication Form dated 12/15/13 indicated: S: Situation: Decreased fluid intake and no bowel sounds that started on 12/15/13. There was no documentation in the spaces regarding whether the condition had gotten worse, better or stayed the same and there was no documentation related to things that made the condition or symptoms worse or better or if the condition had occurred before. B: Background - A section for vital signs was blank. A: Assessment (RN) or Appearance (LPN) There were no notes documented by an RN. Under LPN notes there was documentation in part that patient was lethargic and had decreased fluid and food intake. R: Request: All boxes were left blank. A section labeled Nursing Note indicated in part at 9:00 AM patient was lethargic with decreased fluid and food intake and emergency medical services transported Resident #1 to the emergency room.</p>	F 514			

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F 514	<p>Continued From page 15</p> <p>During a telephone interview on 01/03/14 at 8:23 AM Nurse #5 stated when she assessed a resident she usually documented the information in the nurses notes. She further stated when a resident had a new wound or change in condition they were supposed to fill out an SBAR Communication Form. She stated there should have been an SBAR form for the new wounds on Resident #1's buttocks and thigh dated 12/14/13 and she should have documented the vital signs on the form. She further stated if the documentation was not there then she must have overlooked it and it should have been documented. She stated she did not remember anything about insulin documentation or sliding scale insulin coverage and would have to look at the medical record before she could answer questions about blank spaces.</p> <p>During a telephone interview on 01/03/14 at 9:02 AM the weekend Nursing Supervisor stated there should have been an SBAR Communication Form completed for the open areas on Resident #1's skin on her buttocks and thigh. She further stated nurses were supposed to fill out an SBAR Communication Form anytime there was a change in a resident's condition and that included any new wounds.</p> <p>During an interview on 01/03/14 at 3:17 the Assistant Director of Nursing (ADON) explained nurses were expected to fill out the SBAR Communication Form when a resident had a change in condition and it should be filled out completely. He confirmed there was no SBAR Communication Form for wounds on Resident #1's buttocks and thigh on 12/14/13 and there were no nurse's notes regarding assessment of the wounds. He also confirmed there were blank</p>	F 514			

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F 514	<p>Continued From page 16</p> <p>spaces on the SBAR Communication Form dated 12/15/13 when Resident #1 was lethargic and had decreased food and fluid intake. He explained the SBAR Communication Form was used to document nurse's notes and it was a tool to help nurses to gather all the important information before they called the doctor. The ADON verified Resident #1 had diabetes and received insulin on a daily basis and had sliding scale insulin coverage based on results from finger stick blood sugar checks. He stated nurses were expected to document their initials and the site of the injection on the MAR and if the medication was not given there should be an explanation in the notes section on the back of the MAR. He stated nurses were also expected to document the results of finger stick blood sugars, their initials and the amount of insulin coverage that was given before meals and at bedtime on a daily basis. He further stated if the blood sugar was not checked there should be an explanation in the notes section on the back of the MAR.</p> <p>During an interview on 01/03/14 at 5:12 PM the Director of Nursing (DON) stated it was her expectation for documentation on the SBAR Communication Form and nurses notes to be complete and thorough. She further stated she would have expected to see an SBAR Communication Form completed with documentation about the new wounds on Resident #1's buttocks and thigh on 12/14/13. The DON also stated it was her expectation is to see the MAR filled out completely and if medications were not given, they should be circled and a reason documented as to why the medication was not given in the notes section on the back of the MAR.</p>	F 514			

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F 514	Continued From page 17  2. Resident # 4 was readmitted to the facility 07/24/13 after hospitalization 07/21/13-07/24/13 for pneumonia. Original admitting diagnoses included cerebrovascular accident, hypertension, atrial fibrillation, hypothyroidism, dementia, rheumatoid arthritis and delirium.  Review of the current care plan for Resident #4 noted the following problem areas and approaches: 06/12/13-Potential or actual skin breakdown related to recent fall with facial laceration resulting in surgical repair, rib fractures, decreased mobility and weakness. -skin assessments at least weekly -treatments per order 06/12/13-Requires assistance with activities of daily living (ADL) related to recent history of falls, decreased mobility, difficulty walking, muscle weakness. -monitor weekly skin sweeps  Review of physician orders included, "Skin assessment once weekly-weekly nursing progress note (Tuesday 3-11)." This order was included on the treatment records of Resident #4 with dates blocked off on a weekly basis for completion of the assessment.  The November 2013 treatment record of Resident #4 had blocked out the following dates for the weekly skin assessment: 11/05/13, 11/12/13, 11/19/13 and 11/26/13. The December 2013 treatment record of Resident #4 had blocked out the following dates for the weekly skin assessment: 12/03/13, 12/10/13, 12/17/13, 12/24/13 and	F 514			



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F 514	<p>Continued From page 18 12/31/13.</p> <p>On 01/03/14 at 2:40 PM the facility treatment nurse stated weekly skin assessments should be documented on the Weekly Nursing Progress Notes as well as the Weekly Skin Integrity Review form. The treatment nurse stated after completion and documentation of the assessment the nurse would initial the treatment record to note completion. The treatment nurse stated though both reports should be completed, if either the Weekly Nursing Progress Notes or Weekly Skin Integrity Review form was done it would meet the intent of the skin assessment.</p> <p>The following concerns were identified with the weekly assessments of Resident #4:</p> <ul style="list-style-type: none"> <li>-A Weekly Skin Integrity Review form was located in the medical record of Resident #4 and the last documented assessment was 11/12/13.</li> <li>-The treatment record was not signed on the 11/19/13 area blocked off on the treatment record. There was not a Weekly Nursing Progress Note for 11/19/13 or a Weekly Skin Integrity Review.</li> <li>-The Weekly Nursing Progress Note was done 11/26/13 but the Weekly Skin Integrity Review was not done.</li> <li>-The treatment record was signed on 12/03/13 indicating the weekly skin assessment had been completed. However, there was not a Weekly Nursing Progress Note or Weekly Skin Integrity Review completed for Resident #4.</li> <li>-The treatment record was not signed on the 12/10/13 area blocked off on the treatment record. There was not a Weekly Nursing Progress Note for 12/10/13 or a Weekly Skin Integrity Review.</li> <li>-The Weekly Nursing Progress Note was done</li> </ul>	F 514		

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F 514	<p>Continued From page 19</p> <p>12/17/13 but the Weekly Skin Integrity Review was not done.</p> <p>-The Weekly Nursing Progress Note was done 12/24/13 but the Weekly Skin Integrity Review was not done.</p> <p>-The treatment record was not signed on the 12/31/13 area blocked off on the treatment record. There was not a Weekly Skin Integrity Review and the Weekly Nursing Progress Note only "skin tear left lower extremity; treatment continues" in the area designated for noting any issues with a resident's skin.</p> <p>On 01/02/14 at 4:10 PM the facility treatment nurse reviewed the medical record and treatment record of Resident #4 and verified the 11/19/13, 12/03/13 and 12/10/13 weekly skin assessments had not been completed. The treatment nurse could not explain why the weekly skin assessments had not been completed.</p> <p>On 01/03/14 at 9:30 AM Nurse #6 stated he signed the 12/03/13 weekly skin assessment indicating the assessment had been completed. Nurse #6 stated he could not explain why the Weekly Nursing Progress Note and Weekly Skin Integrity Review had not been completed.</p> <p>On 01/03/14 at 4:35 PM Nurse #7 stated she had completed the 12/31/13 Weekly Nursing Progress Note for Resident #4. Nurse #7 stated she was unaware of the Weekly Skin Integrity Review or that the treatment record was supposed to be initialed when a weekly skin review was completed. Nurse #7 stated she must have forgotten to document on the 12/31/13 Weekly Nursing Progress Note that Resident #4 had an area on his left heel.</p>	F 514			

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F 514	<p>Continued From page 20</p> <p>On 01/03/14 at 5:15 PM the facility Director of Nursing stated she expected weekly skin assessments to be completed and that documentation should all reflect current issues. The Director of Nursing stated the weekly assessment should include documentation on the Weekly Nursing Progress Note and Weekly Skin Integrity Review and should be initialed as completed on the treatment record. The Director of Nursing stated she was unaware the weekly skin assessments had not been completed for Resident #4 on 11/19/13, 12/03/13 and 12/10/13.</p> <p>3. Resident # 3 was first admitted to the facility on 08/29/13, then re-admitted to the facility on 10/01/13 with diagnoses including chronic obstructive pulmonary disease, atrial fibrillation, coronary artery disease and rheumatoid arthritis. The most recent nursing assessment was a quarterly Minimum Data Set (MDS) dated 11/26/13 which indicated the resident did not have any pressure ulcers but was at risk for developing pressure ulcers. The initial care plan dated 08/29/13 addressed Resident # 3's risk for developing pressure ulcers due to her diagnoses, severe disability and occasional incontinence. Interventions included pressure relieving devices to bed and wheelchair. The care plan was updated on 12/23/13 and indicated Resident # 3 had pressure ulcers to her left heel.</p> <p>Review of the nursing documentation on the Weekly Skin Integrity Review for 11/05/13, 11/12/13, 11/19/13, 11/26/13 and 12/04/13 revealed Resident # 3's skin was intact. The next Weekly Skin Integrity Review was dated 12/21/13 and signed by Nurse # 1 but left blank. There was no written documentation of a pressure ulcer and</p>	F 514			

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F 514	<p>Continued From page 21</p> <p>no indication on the figure of the feet that resident had a pressure ulcer on the left heel. The Weekly Skin Integrity Review for 12/28/13 was signed by Nurse # 1 but left blank. There was no written documentation of a pressure ulcer and no indication on the figure of the feet that resident had a pressure ulcer on the left heel.</p> <p>Review of the Weekly Nursing Progress Notes dated 12/21/13 and signed by Nurse # 1 revealed a section titled "Skin" with the instructions: "Review weekly skin checks, pressure and/or non-decub (decubitus) information, physician's orders and care plan." Written in that section was the following note: "no new skin issues within last 7 days."</p> <p>Review of the Weekly Nursing Progress Notes dated 12/28/13 and signed by Nurse # 2 revealed the following documentation in the Skin section: "no new skin issues within p (past) 7 days."</p> <p>Review of wound information provided by Nurse # 3 revealed a form titled Non-pressure Skin Condition Record which indicated Resident # 3 had a venous insufficiency ulcer on her left heel which was found on 12/18/13 that measured 2.8 centimeters (cm) long by 1.6 cm wide which was purple with smooth edges. Nurse # 3 also provided a form titled Pressure Ulcer Record which indicated Resident # 3 had a pressure ulcer on her left lateral heel which was found on 12/23/13 that measured 0.8 cm long by 1.0 cm wide that was unstageable due to yellow slough.</p> <p>Further review of Resident # 3's medical record revealed an Interdisciplinary Progress Note (IPN) dated 12/19/13 which read in part: "IDT</p>	F 514			

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F 514	<p>Continued From page 22</p> <p>(interdisciplinary team) meeting noted DTI (deep tissue injury) to left heel. Skin prep applied as scheduled. Heels floated while in bed. Pressure reducing device to bed." An IPN dated 12/24/13 read in part: "Weekly wound note: resident noted to have DTI to left heel. Wound is fully intact dark purple to center of wound with white noted to outer edge of wound. Scant amount of clear drainage present. Also, noted to left lateral heel was a small unstageable area 100% filled with slough that is hard. Periwound is red. New order for skin prep. MD (physician) aware of status."</p> <p>An interview with Nurse # 3 on 01/02/14 at 4:20 PM revealed she was notified of all residents with pressure ulcers or stasis ulcers so she could measure the wounds. Nurse # 3 stated she measured all wounds every Monday. She stated she discovered the area on Resident # 3's left lateral heel on 12/23/13 when she was measuring the area on the bottom, posterior of the heel.</p> <p>An interview with the Assistant Director of Nursing (ADON) on 01/03/14 at 4:21 PM about the Weekly Nursing Progress Notes and what he expected the nurses to document revealed the document was intended to be a review of the resident's condition over the previous 7 days. He stated if a resident had skin breakdown, he would expect to see that documented on the note.</p> <p>An interview with Nurse # 3 on 01/03/14 at 4:53 PM revealed the area on Resident # 3's heel which was discovered on 12/18/13 was due to pressure and not venous insufficiency. Nurse # 3 stated she documented the wound as a DTI because it was not open when she first assessed it.</p>	F 514			

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345329</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/03/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GATEWAY REHABILITATION AND HEALTHCARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2030 HARPER AVE NW</b> <b>LENOIR, NC 28645</b>		
(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 514	Continued From page 23 An interview with the Director of Nursing (DON) on 01/03/14 at 5:12 PM about her expectation for the accuracy of nursing documentation revealed that she expected the documentation on all forms in the medical record to accurately reflect the resident's condition and coincide with each other. When asked about her expectation for weekly skin assessments, she stated the nurse should check the resident from head to toe and document any skin breakdown on the form even if it had previously been noted. When asked about her expectation for documentation on the weekly nursing summary, she stated any areas of skin breakdown should be documented on the form.	F 514			