STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345377	A. BUILDING ______ B. WING ______	C 01/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELD PLACE	**2575 W 5TH STREET GREENVILLE, NC 27834**

(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 observation, record review, staff and resident interviews, the facility failed to notify the physician as to the discovery of blisters to the	F 157	1. Nurse #1, that was assigned to Resident #6, was counseled and disciplined on 2-3-15 regarding the	2/20/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/13/2015

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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Continued From page 1

right inner and outer knee for 1 of 3 residents (Resident #6) who were reviewed for notification. Findings included:

Resident #6 was admitted to the facility on 08/11/14. Cumulative diagnoses included paraplegia, anemia, prostate cancer and history of a hip fracture.

The most recent Quarterly Minimum Data Set (MDS) of 11/05/14 noted Resident #6 had no problems with cognition. He required extensive to total assistance with all activities of daily living.

An Incident/Accident Report of 01/17/15 which was completed by treatment nurse #1 noted Resident #6 had open blisters to the right outer and right inner knee. It was noted on the report that Resident #6 was his own responsible party and the physician was notified at 12:00 PM on 01/17/15.

A treatment progress note of 01/17/15 written by treatment nurse #1 noted that Resident #6 had a stage 2 to the right inner knee that measured 0.5 centimeters by 1 centimeter and a stage 2 to the right outer knee that measured 2 centimeters by 0.6 centimeters. The wounds were cleaned with normal saline and a [brand name dressing] was applied.

A physician's telephone order of 01/17/15 noted to clean Resident #6's right inner knee with normal saline and apply a [brand name dressing] every 3 days. It was also noted to clean the right outer knee with normal saline and apply a [brand name dressing] every 3 days.

During an observation of personal care on

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importance of timely physician notification in regards to changes in skin integrity.

2. All Nurses were inserviced on 2-9-15 regarding the importance of timely physician notification in regards to changes in skin integrity. All residents in the facility will have a "Skin Integrity Audit" completed by 2-20-15 to ensure that all areas of impaired skin integrity had timely notification of the physician.

3. A "Changes in Skin Integrity Flowchart" was put into place on 2-9-15. The flowchart addresses the following areas:

A. Resident identified
B. Area identified
C. Area assessment
D. Physician notification
E. Responsible party notification
F. Treatment initiated
G. Incident report completion
H. Skin referral form completion
I. Medical record documentation
J. 24 hour report documentation

Once an area of change in skin integrity is identified and reported to the Nurse assigned to the resident a "Change in Skin Integrity Flowchart" will be initiated and completed by the end of the shift. The "Change in Skin Integrity Flowchart" will be signed by the Nurse completing the form and attached to the 24 hour report for review by the management team.

4. The "Change in Skin Integrity Flowchart" will be monitored and reviewed

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F 157	Continued From page 2 01/22/15 at 10:15 AM, Resident #6 was noted to have an undated [brand name dressing] in place to the inner right knee as well as the outer right knee. During an interview with Resident #6 on 01/22/15 at 12:00 PM, he stated he didn't remember exactly which day he noticed the blisters to his right knee but it was last week. He also stated he didn't remember which staff person he had reported the blisters to. An interview was conducted with the physical therapist that was identified as working with Resident #6 last week. On 01/22/15 at 3:00 PM, she stated she worked with Resident #6 daily on strengthening exercises, gait training and mobility. She reported she had been measuring his knees every day that she worked with him due to his request. She stated she remembered seeing blisters to his right knee but she didn't document anything about them. She commented she wasn't sure if it was on Wednesday or Thursday of last week. She also stated she did not notify the nursing staff about the blisters. During a telephone interview with the treatment nurse (treatment nurse #1), on 01/22/15 at 4:15 PM, she stated Nurse #4 had reported the blisters to Resident #6's knee late on Friday afternoon January 16, 2015 as she was leaving. She also stated Nurse #1 had commented that she had forgotten to tell her about the blisters. Treatment nurse #1 reported that she informed Nurse #1 that she would assess the blisters the next day. She reported that she assessed Resident #6's right knee on Saturday, January 17, 2015 but the blisters had erupted and the skin was open. She stated the physician was notified and she started	F 157	using the 24 hour report and direct observation 5 days a week during the daily Interdisciplinary Team Meetings. An audit of a minimum of 3 resident charts will be audited weekly x 4 weeks then monthly x 2 months by Nursing Management to assure compliance with the procedures listed on the "Changes in Skin Integrity Flowchart". The results of these audits will be taken to the facility QA&A Committee meetings. Recommendations will be made based on these audits.	

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treatments of [brand name dressing] every 3 days. She reported that the protocol was for the nurse who discovered the change in skin integrity to start a monitoring sheet to monitor the blisters and once the blisters erupted, treatments were started using [brand name dressings]. Treatment nurse #1 stated the nurse who discovered the issue should have reported it to the physician. Treatment nurse #1 commented that she had 24 hours to assess the resident once she received a skin referral.

Nurse Aide #1 (NA #1) was identified as working with Resident #6 on Wednesday (January 14, 2015), Thursday (January 15, 2015), and Friday (January 16, 2015). On 01/23/15 at 10:00 AM, a telephone interview was conducted with NA #1. She stated she was off on Monday (January 12, 2015) and Tuesday (January 13, 2015) of last week but when she came back to work on Wednesday (January 14, 2015) she noticed the blisters to Resident #6's knee during personal care. NA #1 stated he had 2 small fluid filled blisters to the outer right knee and another blister that had erupted noted to his inner right knee. She commented there was red open skin noted to the area of the erupted blister on the inner right knee. NA #1 stated she reported the blisters to Nurse #1 that day.

Treatment nurse #2 was observed providing wound care to Resident #6 on 01/23/15 at 10:10 AM. She stated she had not seen his wounds as yet and the treatment was to clean with normal saline and apply [brand name dressing]. She stated treatment nurse #1 had told her about the blisters. She removed the undated dressings from both wounds. Treatment nurse #1 cleaned both areas with normal saline and applied a

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[brand name dressing] to both. Resident #6 had no complaints during the procedure.

During a telephone interview with Nurse #4, on 01/23/15 at 10:50 AM, she stated she had worked with Resident #6 last week. She stated she remembered NA #1 coming to her on Wednesday (January 14, 2015) and reported 2 blisters to the outer right leg. Nurse #4 reported that she totally forgot to report the blisters to the treatment nurse that day. She stated she was busy with other residents and had planned to make a late entry into the nurse's notes but had forgotten to do that. Nurse #4 commented she had forgotten about the blisters since she was assigned to work on a different hall the next day. She commented that she was supposed to notify the physician of any new skin issues when discovered and complete a skin referral form for the treatment nurse. Nurse #4 also stated she was also supposed to complete an incident report. Nurse #4 stated she did not do any of those things as she had forgotten about the blisters.

During an interview with the Director of Nurses (DON) and the Assistant DON (ADON), on 01/23/15 at 1:45 PM, the DON stated the nurse who discovered or received report of a change in a resident's skin was responsible for notifying the physician as well as the responsible party. She commented that Resident #6 was alert and oriented and his own responsible party. The DON stated staff members should complete an incident report if needed and initiate a skin referral to the treatment nurse. She stated this notification should be done upon discovery of the change in skin integrity and not 4 days later. The DON also stated any staff person who discovered a change in a resident's skin should be reporting

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F 157	Continued From page 5 it. She stated she expected the therapy department to report any changes in a resident's skin integrity upon discovery to the nursing department so they could assess the area and begin treatment. The ADON stated Nurse #4 didn't report the blisters until she was leaving the building on 01/16/15.	F 157		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 observations, record review, staff and resident interviews, the facility failed to report changes in a resident's skin integrity as evidenced by the development of blisters to the inner and outer right knee and also failed to assess and monitor the blisters for 1 of 2 sampled residents (Resident #6) who were reviewed for impaired skin. Findings included: Resident #6 was admitted to the facility on 08/11/14. Cumulative diagnoses included paraplegia, anemia, prostate cancer and history of a hip fracture. The facility's August 2014 standard physician's orders for skin/wounds noted that any new or worsening skin wounds should be reported to the	F 309	1. Nurse #1, that was assigned to Resident #6, was counseled and disciplined on 2-3-15 regarding the importance of timely physician notification, timely assessment and timely initiation of treatment in regards to changes in skin integrity. The Physical Therapist assigned to work with Resident #6 was counseled and inserviced on 2-5-15 regarding the importance of timely reporting of changes in skin integrity. 2. All facility staff, including the Therapy Department, were inserviced on 2-4-15, 2-5-15, and 2-9-15 regarding the importance of timely reporting of changes in skin integrity. All Nurses were	2/20/15

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physician.

The Admission Minimum Data Set (MDS) assessment of 08/18/14 noted Resident #6 was cognitively intact with no problems in decision making. He required extensive to total assistance with all activities of daily living. The Care Area Assessment (CAA) detail for this assessment indicated he triggered in 8 areas including pressure ulcers and all were to be addressed in his care plan.

Resident #6's care plan of 11/17/14 identified him as being at risk for impaired skin integrity.

The most recent Quarterly Minimum Data Set (MDS) of 11/05/14 noted Resident #6 had no problems with cognition. He required extensive to total assistance with all activities of daily living.

An Incident/Accident Report of 01/17/15 which was completed by treatment nurse #1 noted Resident #6 had open blisters to the right outer and right inner knee. It was noted on the report that Resident #6 was his own responsible party and the physician was notified at 12:00 PM.

A treatment progress note of 01/17/15 written by treatment nurse #1 noted that Resident #6 had a stage 2 to the right inner knee that measured 0.5 centimeters by 1 centimeter and a stage 2 to the right outer knee that measured 2 centimeters by 0.6 centimeters. The wounds were cleaned with normal saline and a [brand name dressing] was applied.

A physician's telephone order of 01/17/15 noted to clean Resident #6's right inner knee with normal saline and apply a [brand name dressing]

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inserviced on 2-9-15 regarding the importance of timely reporting of changes in skin condition, timely notification of the physician and timely initiation of treatment in regards to changes in skin integrity. A "Skin Integrity Audit" will be completed on all residents in the facility by 2-20-15. Any newly found areas of impaired skin integrity will have a "Changes in Skin Integrity Flow Chart" initiated and completed by the end of the shift. This will include timely notification of the physician and responsible party, treatment initiated, completion of incident report and skin referral form and documentation in the medical record and 24 hour report.

3. A "Changes in Skin Integrity Flowchart" was put into place on 2-9-15. The flowchart addresses the following areas:

A. Resident identified
B. Area identified
C. Area assessment
D. Physician notification
E. Responsible party notification
F. Treatment initiated
G. Incident report completion
H. Skin referral form completion
I. Medical record documentation
J. 24 hour report documentation

Once an area of change in skin integrity is identified and reported to the Nurse assigned to the resident a "Change in Skin Integrity Flowchart" will be initiated and completed by the end of the shift. The "Change in Skin Integrity Flowchart" will be signed by the Nurse completing the

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every 3 days. It was also noted to clean the right outer knee with normal saline and apply a [brand name dressing] every 3 days.

Resident #6's revised care plan of 01/19/15 noted stage 2 wounds to the right inner and outer knee.

Resident #6 was observed in bed at 2:50 PM on 01/21/15. He stated he came here for physical therapy after a fall which resulted in a broken hip.

During an observation of personal care on 01/22/15 at 10:15 AM, Resident #6 was noted to have an undated [brand name dressing] in place to the inner right knee as well as the outer right knee.

During an interview with Resident #6 on 01/22/15 at 12:00 PM, he stated he didn't remember exactly which day he noticed the blisters to his right knee but it was last week. He also stated he didn't remember which staff person he had reported the blisters to.

The physical therapist that was identified as working with Resident #6 last week was interviewed on 01/22/15 at 3:00 PM. She stated she worked with Resident #6 daily on strengthening exercises, gait training and mobility. She reported she had been measuring his knees every day that she worked with him due to his request. She stated she remembered seeing blisters to his right knee but she didn't document anything about them. She commented she wasn't sure if it was on Wednesday or Thursday of last week. She also stated she did not notify the nursing staff about the blisters.

During a telephone interview with the treatment

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form and attached to the 24 hour report for review by the management team.

4. The "Change in Skin Integrity Flowchart" will be monitored and reviewed using the 24 hour report and direct observation 5 days a week during the daily Interdisciplinary Team Meetings. An audit of a minimum of 3 resident charts will be audited weekly x 4 weeks then monthly x 2 months by Nursing Management to assure compliance with the procedures listed on the "Changes in Skin Integrity Flowchart". The results of these audits will be taken to the facility QA&A Committee meetings. Recommendations will be made based on these audits.

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nurse (treatment nurse #1), on 01/22/15 at 4:15 PM, she stated Nurse #1 had reported the blisters to Resident #6's knee late on Friday afternoon January 16, 2015 as she was leaving. She also stated Nurse #4 had commented that she had forgotten to tell her about the blisters. Treatment nurse #1 reported that she informed Nurse #1 that she would assess the blisters the next day. She commented that she assessed Resident #6's right knee on Saturday, January 17, 2015 but the blisters had erupted. She stated the physician was notified and she started treatments of [brand name dressing] every 3 days. She reported that the protocol was for the nurse who discovered the change in skin integrity to start a monitoring sheet to monitor the blisters and once the blisters erupted, treatments were to be started using [brand name dressings]. Treatment nurse #1 commented that she was supposed to receive skin referrals on any skin integrity issue. She stated the nurse who discovered the issue should have reported it to the physician. Treatment nurse #1 commented that she had 24 hours to assess the resident once she received a skin referral.

Nurse Aide #1 (NA #1) was identified as working with Resident #6 on Wednesday (January 14, 2015), Thursday (January 15, 2015), and Friday (January 16, 2015). On 01/23/15 at 10:00 AM, a telephone interview was conducted with NA #1. She stated she was off on Monday (January 12, 2015) and Tuesday (January 13, 2015) of last week but when she came back to work on Wednesday (January 14, 2015) she noticed the blisters to Resident #6's knee during personal care. NA #1 stated he had 2 small fluid filled blisters to the outer right knee and another blister that had erupted noted to his inner right knee.

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F 309	Continued From page 9 She commented there was red open skin noted to the area of the erupted blister. NA #1 stated she reported the blisters to Nurse #1 that day. Treatment nurse #2 was observed providing wound care to Resident #6 on 01/23/15 at 10:10 AM. She stated she had not seen his wounds as yet and the treatment was to clean with normal saline and apply [brand name dressing]. She removed the undated dressings from both wounds. She cleaned the 2 small dark reddish areas of the right outer knee with normal saline and applied a [brand name dressing]. The reddish areas were approximately 0.5 centimeters by 0.5 centimeters each or about the size of a pencil eraser. Treatment nurse #2 cleaned the open area to the inner right knee with normal saline. Initially the center of the wound had yellow slough but after she cleaned the wound the center was dark pink. The wound was round in shape, slightly sunken with raised pink edges and was approximately 2 centimeters by 2 centimeters. The open area was surrounded by approximately 0.5 centimeters of darker red tissue. Treatment nurse #2 covered the stage 2 with a [brand name dressing]. Resident #6 had no complaints during the procedure. During a telephone interview with Nurse #4, on 01/23/15 at 10:50 AM, she stated she had worked with Resident #6 last week. She stated she remembered NA #1 coming to her on Wednesday (January 14, 2015) and reported 2 blisters to the outer right leg. Nurse #4 reported that she totally forgot to report the blisters to the treatment nurse that day. She stated she was busy with other residents and had planned to make a late entry into the nurse's notes but had forgotten to do that. Nurse #4 commented she had forgotten about	F 309		

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

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F 309	Continued From page 10 the blisters since she was assigned to work on a different hall the next day. She commented that she was supposed to notify the physician of any new skin issues when discovered and complete a skin referral form for the treatment nurse. Nurse #4 also stated she was also supposed to complete an incident report. Nurse #4 stated she did not do any of those things as she had forgotten about the blisters. During an interview with the Director of Nurses (DON) and the Assistant DON (ADON), on 01/23/15 at 1:45 PM, the DON stated the nurse who discovered or received report of a change in a resident's skin was responsible for notifying the physician as well as the responsible party. She commented that Resident #6 was alert and oriented and his own responsible party. The DON stated staff members should complete an incident report if needed and initiate a skin referral to the treatment nurse. She stated this notification should be done upon discovery of the change in skin integrity and not 4 days later. The DON also stated any staff person regardless of discipline who discovered a change in a resident's skin should be reporting it. She stated she expected the therapy department to report a change in a resident's skin integrity to the nursing department so they could assess the area and begin treatment. The ADON stated Nurse #1 didn't report the blisters until she was leaving the building on 01/16/15.	F 309		