STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING ______ B. WING ______	C 09/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	111 HARRILSON STREET CHERRYVILLE, NC 28021

(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 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 observation, record review, and resident and staff interviews the facility failed to apply cream and change foot wound dressings for three days that were ordered to be done twice daily for 1 of 3 residents reviewed for wound care. (Resident #4) The findings included: Resident #4 was admitted to the facility on 08/25/15 with diagnoses which included diabetes and osteomyelitis of the right metatarsal. No Minimum Data Set had been completed due to recent admission. An admission progress note dated 08/25/15 read in part " ...Right foot 3rd digit between 2nd digit and 3rd digit noted red and inflamed with area of brown soft eschar measuring 2cmL (centimeters long) x 1.8cmW (centimeters wide). Digits absence of toenails. Tissue has dry thick layers of peeling. Layers of skin lifting around 4th and 5th digit. Noted area to top of left foot with black eschar, spongy feeling measuring 1.5cmL x 9cmW. Resident states that the Dr. ' s office has been cutting away eschar on this foot. Noted amputation site on left foot great toe area has two open wounds which are pink and moist, Left outer area measures 1.7cmL x 1.7cmW. Inner area	F 309	Carolina Care continues to provide care to maintain highest practicable well being to the residents. 1. Corrective action for treatment not being completed. Resident treatment ordered two times per day. Treatment not completed on resident #4. Discharge summary from the hospital had an order for dry dressing with emulsion cream. Physician order corrected to include dressing to feet bilateral. Licensed personnel disciplined for not completing treatment ordered. Treatment completed on resident #4 per physician order. 9/2/15 2. Corrective action for other residents having potential to be affected by the alleged deficient practice was corrected by other in-house residents checked for accurate and timely dressing changes. All other resident's treatments had been completed timely. 9/2/15	9/25/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 09/21/2015

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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F 309	Continued From page 1 measures 1.5cmL x 1.5cmW ... " Review of Treatment Administration Record (TAR) revealed a physician order for Sonofine cream to be applied topically to affected areas of bilateral feet twice per day and apply a dry dressing. The TAR had been initialed by nurses as having been completed twice per day starting 08/26/15 through 09/01/15. On 09/02/15 at 9:10 AM an observation was made of Resident #4 sitting up in her wheelchair in her room. Resident #4 had dressings on both feet. Each dressing had a date of 08/30/15 written on the top. On 09/02/15 at 1:54 PM an observation was made of Nurse #1 changing the dressings on Resident #4's feet. The dressing dated 08/30/15 was removed from Resident #4's left foot there was no drainage noted. There was an area of black escar noted on the top of the left foot. Resident #4's left great toe had been amputated. The right foot dressing was removed and there was a large area of wet slough brownish skin noted to the third toe, this area measured 1.1 cm x 0.9 cm. An interview was conducted on 09/02/15 at 9:10 AM with Resident #4. Resident #4 stated she had come to the facility for intravenous infusions of antibiotics and for dressing changes to her feet. She stated the dressings to her feet were not changed every day. On 09/02/15 at 11:30 AM an interview was conducted with Nurse #1 who was the wound treatment nurse for the facility. She stated Resident #4's dressings were ordered to be changed twice per day. She stated she had not worked with Resident #4 since 08/28/15. She stated she did not know why the dressings had not been changed since 08/30/15. An interview was conducted 09/02/15 at 1:54 PM	F 309	3. Measures put in place to ensure alleged deficient practice does not recur include the following: In-service completed on treatment protocol, processing of orders correctly and the importance of completing treatment before signing ETAR. Treatments continue to be placed on the electronic treatment record for nurse to initial when treatment is completed. 9/2/15,9/18/15 4. Monitors put in place to ensure proper treatment orders/dressing changes are completed timely and accurately. First Shift Supervisor or Admission Nurse will complete audits weekly for one year. 9/14/15 Audit results are reviewed in the Quality Assurance Tracking meeting weekly. 9/15/15 Audit results are reviewed monthly in the Quality Assurance and Assessment Committee to determine the effectiveness or change in procedure or plan.9/24/15 Quality Assurance and Assessment Committee reviews QA Tracking Reports for one year. 9/24/15	

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F 309	Continued From page 2	F 309		

with Nurse #1, the treatment nurse during Resident #4's dressing change. She stated the right foot has osteomyelitis and they were afraid Resident #4 would lose her third toe. She stated the resident did not want the doctor to remove the toe which was why she was receiving IV antibiotics and wound care on the right third toe.
On 09/02/15 at 3:12 PM an interview was conducted with Nurse #2 who worked with Resident #4 first shift on 08/31/15. She stated the treatment nurse had not worked that day and she was expected to complete all wound treatments on her assigned residents. She stated she did not apply the cream nor change the dressings on Resident #4's foot wounds that day. She went on to say that it was her error for not having done so.
On 09/02/15 at 3:27 PM an interview was conducted with the Director of Nursing (DON). The DON stated it was her expectation that wound treatments should be completed as ordered by the physician. She further stated the nurses should not document the treatment has been done until after they have completed the wound treatment. The DON further stated that if a treatment is ordered twice per day it should be done once on first shift and again on second shift.
On 09/02/15 at 3:41 PM an interview was conducted with Nurse #3 who worked 2nd shift with Resident #4. Nurse #3 stated the majority of the time she did her own treatments for the residents she was assigned to. She stated that Nurse #4 had been assigned to complete treatments on 09/01/15 during 1st shift but she spoke with her after 3:00 PM and Nurse #4 stated she was going to do the wound care for Resident #4. She stated she should not have signed that she had done the treatment unless she had done it.
A telephone interview was conducted on 09/02/15

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F 309	Continued From page 3 at 4:06 PM with Nurse #4. Nurse #4 stated on 09/01/15 she had gone into Resident #4's room to change her dressings but the resident was not in the room. She stated she left the wound cream in Resident #4's room and intended to go back to apply the cream and change the dressings. She stated she should have gone back and amended the Treatment record as not having applied the cream to the wounds. She stated she did not tell the 2nd shift nurse the treatments had not been done to Resident #4's feet. Nurse #4 further stated if a treatment was ordered to be done twice per day it should be done in the morning and again on 2nd shift.	F 309		