| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 314 SS=D | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and interview with wound care specialist, nurse practitioner and staff, the facility failed to follow the treatment plan as recommended by the wound doctor for 1 (Resident #2) of 3 sampled residents reviewed for pressure ulcers. Findings included:<br>Resident #2 was admitted to the facility on 6/3/16 with multiple diagnoses including Diabetes Mellitus and Hypertension. The quarterly Minimum Data Set (MDS) assessment dated 9/10/16 indicated that Resident #2's cognition was intact and she had a stage III pressure ulcer that was not present on admission.<br>Resident #2's care plan was reviewed. The care plan dated 9/10/16 addressed the stage III pressure ulcer on the left heel. The goal was for the current ulcer not to worsen through the next review date. The approaches included to place the resident on pressure relieving products such as pressure relieving mattress and chair cushion as appropriate and to treat current ulcer per doctor's order.<br>Resident #2's weekly wound assessments were | F 314 | F314<br>On 10/12/16 the Director of Nursing (DON) contacted the attending physician for clarification of the wound physician□'s 9/22/16 recommendation for Resident # 2. The order was not changed and the Santyl was not restarted, as the Optum Nurse Practioner (NP) had ordered on 9/20/16.<br>On 10/12/16 the DON initiated a review of 100% of the most recent Wound Physician recommendations to ensure recommendations had been followed up on, with new orders present or documentation from attending Physician of non-agreement. This review was completed on 10/14/16 by the DON and Treatment nurse. There was 1 discrepancy found with the frequency of the hydrocolloid dressing change, the order was to change dressing every 7 days and Wound physician's recommendations is to change every 3 days. the order was clarified to follow | 10/18/16 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/18/2016

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| F 314 | Continued From page 1<br>reviewed. The assessment dated 8/21/16 indicated that Resident #2 had developed a suspected deep tissue injury (DTI) to the left heel. The assessment revealed that the DTI was 1 X (by) 2 centimeter (cm.) purple in color with blister on top. The physician and the responsible party were notified. The DTI was treated with Duoderm (hydrocolloid dressing) and Tegaderm (transparent dressing) per facility protocol.<br>Resident #2's wound care specialist evaluation forms were reviewed. The form dated 8/25/16 revealed that the resident had a stage III pressure ulcer on the left heel measuring 3 x 4 x 0.1 cm. with moderate serosanguinous exudate. The form indicated the pressure ulcer had some DTI and the treatment plan was Santyl (debriding agent) and Calcium Alginate (absorbs exudate) and foam dry protective dressing daily.<br>The wound care specialist evaluation form dated 9/1/16 indicated that the stage III pressure ulcer on the left heel had no change with the same measurement and with moderate serous exudate. The treatment plan was to discontinue the calcium alginate and to start collagen dressing (absorbs exudate) with Santyl and foam dry protective dressing and to change the dressing daily.<br>The wound care specialist evaluation form dated 9/8/16 revealed that the pressure ulcer on the left heel had decreased surface area measuring 3 x 3.5 x 0.1 cm and with moderate serous exudate. The treatment plan was the same, Santyl with collagen dressing and foam dry protective dressing and to change the dressing daily.<br>The wound care specialist evaluation form dated 9/15/16 revealed that the stage III pressure ulcer on the left heel had decreased surface area measuring 2.6 x 2.6 x 0.1 cm with moderate serous exudate. The treatment plan was the | F 314 | Wound physician recommendation of change every 3 days. Any discrepancies found were corrected immediately.<br>On 10/18/16 the Assistant Director of Nursing (ADON) began in servicing 100% of licensed nurses in the procedure of processing consultation reports. All licensed nurses will be in serviced by 10/18/16. No licensed nurse will be allowed to work after 10/18/16 until this in-service is completed. This in-service will be added to the orientation process for all licensed nurses.<br>On 10/21/16 the DON/ADON will begin auditing 100% of wound physician consultations weekly x 6 weeks then 50% weekly x 6 weeks to ensure follow up of recommendations is present. This audit will be documented on the Wound Care Consultation Audit Tool.<br>At next scheduled Executive Quality Improvement (QI) Committee the DON/Administrator will present the results of the Wound Care Consultation audits to the Executive QI Committee for 3 months, then times 3 by the monthly QI Committee for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance and oversight. | |

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same, Santyl with collagen dressing and foam dry protective dressing daily.
Resident #2 had a doctor's order dated 9/20/16 to discontinue Santyl to left heel due to no slough or eschar and for the wound doctor to see Resident #2 on 9/23/16. The order was a verbal order from Nurse Practitioner #1.
The physician progress notes form dated 9/20/16 revealed that a staff nurse observed Resident #2's left heel and there was no slough or eschar noted. A verbal order was given to discontinue Santyl and to keep dressing daily until seen by the wound doctor on 9/22/16 (Thursday).
The wound care specialist evaluation forms were reviewed. The form dated 9/22/16 revealed that Resident #2's left heel pressure ulcer had decreased surface area measuring 2.2 x 2.5 x 0.1 cm and with moderate serous exudate. The treatment plan was to continue with Santyl and collagen dressing and foam dry protective dressing to be changed daily.
The wound care specialist evaluation form dated 9/29/16 revealed that the left heel pressure ulcer had no change measuring 2.2 x 2.5 x 0.1 cm and with moderate serous exudate. The treatment plan was to continue the Santyl and collagen dressing and foam dry protective dressing to be changed daily.
Resident #2's treatment administration records (TARs) were reviewed. The September 2016 TAR revealed that protective dressing was provided daily to Resident #2's stage III pressure ulcer on the left heel from 9/ 20 through 9/30 and on 10/01 through 10/10/16.
On 10/11/16 at 4:05 PM, the wound care specialist was interviewed. He stated that he visited residents at the facility including Resident #2 and assessed their pressure ulcers once a week. The wound care specialist indicated that

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| F 314 | Continued From page 3 | F 314 | | |

he expected the facility to follow the treatment plan he recommended during his visits.
On 10/11/16 at 4:25 PM, Resident #2 was observed during the dressing change. Nurse #2 provided the dressing change to the resident's left heel pressure ulcer by cleaning the ulcer with Normal Saline, covered with Medipore dressing (adhesive wound dressing) and 4 x 4 dry gauze and secured with Kerlix. The ulcer was observed to have a red wound bed.
On 10/11/16 at 4:45 PM, Nurse #3 was interviewed. She stated that she made rounds with the wound care specialist once a week on Thursdays. Nurse #3 stated that she removed the old dressing for the wound care specialist to assess the wound and then she provided the treatment to the wound after the wound care specialist finished with his assessments. She revealed that she remembered cleaning the Resident #2's pressure ulcer with Normal Saline and she applied Santy to the wound bed and covered with protective dressing. Nurse #3 stated that she did not know that Santyl was discontinued on 9/20/16 and if she had known she should have written a new order for Santyl as what the wound care specialist had recommended.
On 10/11/16 at 6:25 PM, the Director of Nursing (DON) was interviewed. She stated that she expected the staff to follow the recommendation from the wound care specialist except if the recommendation was outside the facility's wound protocol and the staff has to seek clarification from the doctor. The DON added that she had in-serviced the staff recently that Santyl can be used to treat wounds/ulcers with a granulation tissue as it promotes healing.
On 10/11/16 at 7:05 PM, the DON provided additional information. She stated that she was

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| F 314 | Continued From page 4<br>not aware that the wound care specialist continued to write on his notes to continue Santyl after it was discontinued by the Nurse Practitioner on 9/20/16. She expected the wound care specialist to communicate with the primacy physician or the Nurse Practitioner if he wanted to continue the Santyl.<br>On 10/12/16 at 9:01 AM, Nurse Practitioner (NP) #1 was interviewed. She stated that if she had given an order to discontinue the Santyl and for the resident to be seen by the wound care specialist, she would expect the facility to follow the treatment plan as recommended by the wound care specialist. NP #1 further indicated that if the facility had a concern with the treatment plan the wound care specialist had recommended, the facility should have discussed the concern with the Nurse Practitioner who was in the building every day. | F 314 | | |
| F 325 SS=D | 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE<br><br>Based on a resident's comprehensive assessment, the facility must ensure that a resident -<br>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and<br>(2) Receives a therapeutic diet when there is a nutritional problem.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation, and staff | F 325 | F325 On | 10/18/16 |

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| F 325 | Continued From page 5<br>interview, the facility failed to provide the nutritional supplement and enriched meal plan as recommended by the Registered Dietician (RD) and ordered by the physician for 2 (Residents #4 & #5) of 3 sampled residents reviewed for nutritional status. Findings included:<br>1. Resident #4 was admitted to the facility on 9/10/14 with multiple diagnoses including Hypertension. The significant change in status Minimum Data Set (MDS) assessment dated 9/22/16 indicated that Resident #4 had severe cognitive impairment with brief interview for mental status (BIMS) score of 7. The assessment also indicated that Resident #4's weight was 112 pounds (lbs.) and she had a weight loss. The assessment revealed that the resident was not on a prescribed weight loss regimen.<br>The care plan dated 9/22/16 addressed Resident #4's significant weight loss. The goal was for Resident #4 to demonstrate weight stability through the next review date. The approaches included to refer to dietician for evaluation/recommendations.<br>Resident #4's weights for the last 6 months were as follows:<br>4/20/16 - 134 lbs.<br>5/22/16 - 131 lbs.<br>6/1/16 - 127 lbs.<br>7/20/16 - 120 lbs.<br>8/12/16 - 117 lbs.<br>9/14/16 - 112 lbs.<br>10/10/16 - 113 lbs.<br>The dietary notes for Resident #4 were reviewed. The notes dated 9/21/16 indicated that the resident had a significant weight loss of 18.5% in the last 180 days. The notes revealed that the resident was on a regular diet and had consumed a recorded average of 47.8%. The notes further | F 325 | 10/18/16, the Assistant Director of Nursing (ADON) assessed resident # 4 and resident # 5 for dry skin, dry mucus membranes, hunger, and current weight. Residents # 4 and # 5 were also seen by attending Physician on 10/18/16 to further address weight loss.<br>On 10/18/16, the Dietary Manager/Registered Dietician audited 100% of residents on Enriched Meal Program (EMP) diet, to ensure the tray cards were correct. There were 5 residents with discrepancies noted, on all 5 residents the telephone order was EMP and the tray card was EMP, but the diet order was not EMP in Point Click Care (Electronic Medical Record). RD entered all corrected diet orders as diet clarification as EMP; all discrepancies were corrected immediately.<br>On 10/17/16, the Dietary Manger/Registered Dietician (RD) audited 100% of the RD recommendations for the last 30 days to ensure appropriate orders had been obtained and communicated to the dietary department. This audit included ensuring the diet slips were 100% correct, all other recommendations were carried out and processed correctly.<br>On 10/18/16, the ADON began in servicing 100% of all licensed nursing staff on the procedure for following up on RD recommendations including communicating to the dietary department. All licensed nursing staff will be in serviced by 10/18/16. After 10/18/16 no licensed nursing staff will be allowed to work until in service is completed. This in service will be added to the orientation | |

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| F 325 | Continued From page 6<br>indicated that the resident had refused to eat meals at times. The RD had recommended a nutritional supplement with meals.<br>Resident #4's physician's orders were reviewed. On 9/21/16, there was a doctor's order to begin the nutritional supplement 3 times a day with meals for weight loss.<br>On 10/11/16 at 12:45 PM, Resident #4 was observed during a lunch meal. Her meal tray did not contain the nutritional supplement. The nutritional supplement was not listed on her dietary card.<br>On 10/11/16 at 1:30 PM, Medication Aide #1, assigned to Resident #4 was interviewed. She stated that the nutritional supplement ordered with meals was provided by dietary and placed on the meal tray. She added that she did not check the meal tray for the supplement. Medication Aide #1 stated that the supplement was written on the Medication Administration Record (MAR) as an FYI (for your information) and she had to place a check mark on it.<br>On 10/11/16 at 5:30 PM, Resident #4 was observed during supper. Her meal tray did not contain the nutritional supplement. The nutritional supplement was not listed on her dietary card.<br>On 10/11/16 at 5:45 PM, Nurse #1 was interviewed. Nurse #1 was assigned to Resident #4. She stated that she did not check the resident's tray for any supplements ordered with meals because dietary were expected to provide the supplements with the meal tray. She also indicated that she was the one who signed off the order for the nutritional supplement on 9/21/16 and she made a copy of the order and brought it to the dietary department.<br>On 10/11/16 at 5:55 PM, the RD was interviewed. He indicated that he had recommended the | F 325 | process for all new licensed nursing staff.<br>On 10/18/16, the ADON began in servicing 100% of CNA staff on how to read a tray cards for supplements and the procedure to obtain missing items from the tray cards. This in service will be completed by 10/18/16. After 10/18/16 no CNA staff will be allowed to work until in service completed. This in service will be added to the orientation process for all new CNA staff.<br>On 10/18/16, the Dietary Manager/Registered Dietician began in servicing all dietary staff on how to read a tray card, including making sure all listed supplements are on each tray. This in service will be completed by 10/18/16. After 10/18/16, no dietary staff member will be allowed to work until in service is complete. This in service will be added to orientation for all new dietary staff members.<br>On 10/19/16, the ADON will begin auditing 100% of RD recommendations weekly x 6 weeks then 50% weekly x 6 weeks to ensure follow up is complete including communication to dietary. This audit will be documented on the RD audit tool.<br>On 10/12/16, the Dietary Manger/Registered Dietician began auditing 100 % of trays three times weekly x 2 weeks then one time weekly times 6 weeks and monthly for one month to ensure all supplements listed on tray card are placed onto resident tray. This audit will be documented on the Tray audit tool.<br>The Director of Nursing (DON)/Administrator will present the results of the RD audit tool, and the | |

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| F 325 | Continued From page 7<br>nutritional supplement for Resident #4 due to weight loss. The RD revealed that the nurse should have informed dietary of the new order for the supplement and then dietary should have entered the supplement on the dietary card. He added that he didn't know what happened but obviously dietary did not get the order and therefore was not on the dietary card.<br>On 10/11/16 7:18 PM, the administrator was interviewed. She stated that nursing failed to inform dietary of the new order for the nutritional supplement.<br><br>2. Resident #5 was initially admitted to the facility on 12/12/13 and readmitted on 1/8/16 with multiple diagnoses that included dementia and aphasia.<br><br>The Registered Dietician (RD) progress note dated 1/26/16 indicated Resident #5 had a weight of 125 pounds. Resident #5 was assessed as dependent on staff for eating. Staff's documentation indicated Resident #5 had consumed an average of 50% over her past 10 meals. A recommendation was made to add ice cream with Resident #5's lunch and dinner.<br><br>A physician's order dated 1/26/16 indicated the addition of ice cream at lunch and dinner for Resident #5.<br><br>The quarterly Minimum Data Set (MDS) assessment dated 3/31/16 indicated Resident #5 had significant cognitive impairment. She was assessed as dependent on staff for eating. She had no swallowing issues. Resident #5's documented weight was 123# and she had no significant weight loss. | F 325 | DON/Administrator will present the results of the Tray audit tool to the Executive Quality Improvement (QI) committee monthly x 3 months, then 3 times to the Monthly QI Committee for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance and oversight. | |

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The plan of care for Resident #5 dated 4/14/16 indicated she was at nutritional risk for weight loss. The goal was for Resident #5 not to experience significant weight loss through the next review date. The approaches included the provision of her diet as ordered.

A review of Resident #5's medical record revealed the following weight documentation for the last 6 months:

04/15/16: 123 pounds
05/09/16: 123 pounds
06/08/16: 119 pounds
07/06/16: 117 pounds
08/04/16: 114 pounds
09/02/16: 108 pounds
09/05/16: 105 pounds
10/04/16: 104 pounds

A physician's order dated 5/5/16 indicated Resident #5 was to begin the Enrichment Meal Program (EMP).

A significant change MDS dated 9/18/16 indicated Resident #5 had significant cognitive impairment. She was assessed as dependent on staff for eating. Resident #5 had no swallowing issues and was on a mechanically altered and therapeutic diet. Her weight was indicated to be 105 pounds, she was assessed as having had a significant weight loss, and was not on a physician prescribed weight loss regimen. The Care Area Assessment revealed Resident #5 had significant weight loss related to greater than 25% of her food left uneaten. Resident #5 was indicated to consume a recorded average of 30% of her food.

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A dietary progress note dated 9/19/16 revealed Resident #5 had a significant change in condition. Her weight on 9/5/16 of 105 pounds was indicated to be a 14.3% weight loss in the last 180 days. Resident #5 had consumed an average of 30%. The note indicated Resident #5 was on an EMP diet that included enriched milk three times daily, enriched oatmeal at breakfast, and enriched potatoes and ice cream at lunch and dinner.

An observation was conducted on 10/11/16 at 1:15 PM of Resident #5 at her lunch meal. Resident #5 was being fed lunch in her room by NA #1. Resident #5's dietary slip was observed and it indicated she was to receive 8 ounces (oz) of EMP milk, EMP potatoes, and a half cup of ice cream. Resident #5 had no EMP milk or ice cream on her meal tray.

An interview was conducted on 10/11/16 at 1:45 PM with NA #1. He revealed Resident #5 had not received EMP milk or ice cream with her lunch. NA #1 indicated Resident #5 had consumed about 25% of her lunch.

An observation was conducted on 10/11/16 at 5:35 PM of Resident #5's dietary slip and dinner tray. The dietary slip indicated she was to receive 8oz of EMP milk, EMP potatoes, and a half cup of ice cream. Resident #5 had no ice cream on her meal tray.

An interview was conducted with the Registered Dietician (RD)/Dietary Manager (DM) on 10/11/16 at 6:00 PM. He stated he was the RD at the facility as well as the DM. He explained that the EMP diet varied from resident to resident depending on their needs and preferences. He

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| PINE RIDGE HEALTH AND REHABILITATION CENTER | 706 PINEYWOOD ROAD THOMASVILLE, NC 27360 |

| (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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indicated residents who were ordered the EMP diet had the required enriched food items listed on their dietary slip. He stated this was how the dietary staff knew what to include on each resident's meal tray. Resident #5's physician's order for the EMP diet dated 5/5/16 was reviewed with the RD/DM. He confirmed Resident #5 continued to receive the EMP diet. The observation of Resident #5's lunch meal tray that had not included EMP milk or ice cream was reviewed with the RD/DM. The observation of Resident #5's dinner meal tray that had not included ice cream was reviewed with the RD/DM. He indicated his expectation was for dietary staff to read the dietary slip and to include all listed items on the meal tray. The RD/DM revealed staff were not required to document that the resident received the EMP foods. He stated that staff documented a total percentage of each meal's intake, but had not documented any detailed intake percentage for EMP foods.

An interview was conducted with the Director of Nursing on 10/11/16 at 6:21 PM. She indicated her expectation was for physician's orders for nutritional supplements to be followed.