STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345234	A. BUILDING _____ B. WING _____	C 04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUMBERTON HEALTH AND REHAB CENTER	1555 WILLIS AVENUE LUMBERTON, NC 28358

(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
E 000	Initial Comments An unannounced Recertification survey was conducted on 04/01/19 through 04/04/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # H3SM11.	E 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to complete weekly non-pressure ulcer wound assessments for 1 of 4 sampled residents (Resident #215) reviewed for wounds. Findings included: In the facility's Skin Management Practice Guidelines, revised July 2017, it was documented, "(Non-Pressure Wounds) will be assessed weekly and status/progress documented on the Weekly Non-Pressure Skin Condition Record." Resident #215's 10/11/18 hospital Discharge Summary documented, "Cellulitis and abscess of coccyx: treated with IV (intravenous) clindamycin (antibiotic) and will continue with oral clindamycin x 7 days. Wound care consulted and pt (patient) has a deep tissue injury." Record review revealed Resident #215 was admitted to the facility on 10/11/18. The	F 658	Facility failed to complete weekly non-pressure documentation for resident #215. This resident was discharged on 11/9/2018. All residents have the potential to be affected by this practice. An audit will be completed by the Director of Nursing or Assistant Director of Nursing to insure there is weekly documentation on current residents with non-pressure areas. Any negative findings will be updated with current status/measurements by 4/19/19. All licensed nurses will be educated on documentation expectations of non-pressure areas on or before 4/19/19 by the Director of Nursing or Staff Development Coordinator. This education will be part of orientation for licensed nurses. The Director of Nursing or Assistant Director of Nursing will conduct an audit	4/19/19

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

Electronically Signed | 04/12/2019

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F 658	Continued From page 1 resident's documented diagnoses included hip fracture, diabetes, anemia, peripheral vascular disease, and hypertension. A 10/11/18 physician order started Resident #215 on clindamycin 300 milligrams (mg) every 8 hours x 7 days. (Review of the resident's medication administration record revealed the resident received the antibiotic as ordered from 10/11/18 through 10/18/18). Resident #215's 10/11/18 Nursing Admission Data Collection form documented she had two pressure ulcers to the sacrum, one measuring 2.2 x 1.8 centimeters (cm) and the other measuring 3.3 x 2.8 cm. Nurse #5 did not document stage or description of the wound beds in this skin assessment. A 10/12/18 progress note documented, "She (Resident #215) states she has an open area near her bottom that was hard and originated prior to her fall. She states it busted while she was on the toilet one day and was infected." The resident's 10/18/18 admission minimum data set (MDS) documented the resident's cognition was intact, she exhibited no behaviors including resistance to care, she required extensive assistance from staff to being dependent on staff for her activities of daily living (ADLs) except for being independent with eating, and she had no ulcers but did have a surgical wound. A 10/18/18 physician progress note documented, "...No rashes or skin breakdown....Surgical wounds covered with clean dressings, no erythema or drainage present."	F 658	on a minimum of five residents with non-pressure areas to ensure necessary documentation is completed weekly x 4 weeks, then every 2 weeks x 2, then monthly x 1. Findings will be taken to QAPI monthly x 3 months. The Director of Nursing will be responsible for oversight and monitoring of the non-pressure documentation.	

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F 658	Continued From page 2	F 658		

A 10/26/18 Weekly Non-Pressure Condition Record documented Resident #215 was admitted on 10/11/18 admitted with an abscess site to her sacrum. "Upon assessment, depth noted. Moderate yellow exudate (drainage) present, maceration noted." Nurse #4 documented there was partial skin thickness and yellow slough in the wound bed with moderate serosanguineous drainage but no odor. She also documented the wound had pink wound edges, and the resident was experiencing no pain related to the abscess.

A 11/08/18 physician progress note contained no documentation about the skin impairment to Resident #215's sacrum.

Record review revealed Resident #215 was discharged home with her family on 11/09/18.

On 04/04/19 at 11:14 AM Nurse #2 stated during October/November 2018 the facility was without an official Treatment Nurse, but she helped with wound assessments sometimes during this period. She reported she remembered that Resident #215 had some type of skin integrity issue on her bottom, but could not recall exactly what it was. She commented the resident did not really want staff other than her family member (who was one of the facility's unit managers) looking at her bottom. According to Nurse #2, within the last month and a half she had become the facility's Treatment Nurse, and in her role, she completed an initial assessment of all wounds and weekly wound assessments thereafter.

On 04/04/19 at 12:33 PM Nurse #3, Resident #215's primary direct care nurse, stated the resident had what appeared to be an opened cyst on her bottom. She reported the resident's family

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F 658	Continued From page 3	F 658		

member, a unit manager in the facility, knew the history of the wound and looked after it.

On 04/04/19 at 12:50 PM Nursing Assistant (NA) #1, Resident #215's primary NA, stated since the resident was continent, just needed assistance getting to the bathroom, and could assist with bed baths she could not remember that much about a wound to the resident's sacrum. She reported the resident never talked about the wound to her.

On 04/04/19 at 3:28 PM the Director of Nursing (DON) stated when a resident was admitted to the facility with a wound of any type, there should an initial assessment of the wound followed by weekly wound assessments until the wound healed or the resident was discharged. She reported not assessing wounds weekly could result in wound infections and wound declines not being recognized in a timely manner. She commented a family member identified the wound to Resident #215's bottom as a boil that had ruptured.

On 04/04/19 at 3:40 PM, during a telephone interview, Nurse #4 (the other unit manager in the facility not related to Resident #215) recalled seeing the wound to Resident #215's sacral area several times during the resident's stay in the facility. She reported the wound bed always had a yellowish sloughy appearance area with minimal drainage. She commented she was told by the resident's family that the sacral wound was a cyst/boil that had ruptured or had been debrided. According to Nurse #4, she thought the wound to Resident #215's sacrum got smaller while in the nursing home. Nurse #4 stated there should be weekly assessments for non-pressure wounds that included measurements,

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F 658	Continued From page 4 descriptions of the wound beds, and documentation about the treatment orders. On 04/04/19 at 3:52 PM, during a telephone interview, Nurse #5 (who completed Resident #215's admission nursing assessment) stated when she completed the wound section of an admission assessment she tried to be very thorough and record documentation about bruising, skin tears, and ulcers. She explained if she noted the presence of a pressure ulcer, but did not stage it, that meant there was no open area and the tissue was blanchable (stage I). She reported sometimes the Treatment Nurse would assess wounds behind the admitting nurse, and the Treatment Nurse was always supposed to complete weekly wound assessments thereafter.	F 658		