STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345465	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYVIEW NURSING & REHAB CENTER	**3003 KENSINGTON PARK DRIVE NEW BERN, NC 28560**

(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 10/7/19 through 10/10/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #O00B11.	E 000		
F 000	INITIAL COMMENTS An on-site recertification and complaint survey was conducted on 10/7/19 through 10/10/19. 2 of 8 alligations were subtantiated. Event ID #O00B11.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interviews and Physician interview he facility failed to provide a dressing change treatment as ordered by the physician to an opened blister on the shin for 1 of 3 residents reviewed for wound care. (Resident #13) Findings included: Resident #13 was admitted to the facility on 3/7/18. His active diagnoses included anemia, dementia, and muscle weakness.	F 684	Bayview Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with the applicable rules and the provision of quality care to residents. Submission of this response to the statement of deficiencies by the undersigned does not constitute an admission that the deficiencies existed and/or correctly	10/31/19

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

Electronically Signed | 10/21/2019

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F 684	Continued From page 1 Resident #13 ' s minimum data set assessment dated 8/6/19 revealed he was assessed as severely cognitively impaired. Resident #13 had no skin issues at that time. Resident #13 ' s care plan dated 9/30/19 revealed he was care planned to be at risk for skin breakdown. The interventions included to administer treatments per orders. Resident #13 ' s orders revealed on 9/17/19 he was ordered to have the open blister to his right lower shin cleansed with normal saline, patted dry, moistened Aquacell AG applied, and covered with Allevyn every other day until healed. Resident #13 ' s September 2019 treatment administration record (TAR) revealed on 9/19/19 the treatment to his right lower shin was performed as ordered, but on 9/21/19 the TAR reflected the resident did not have his dressing changed as ordered. During an interview on 10/8/19 at 11:55 AM Resident #13 ' s family member stated on 9/21/19 Resident #13 was supposed to have his dressing changed and the dressing still had a date of 9/19/19. She stated family spoke to Nurse #1 who informed the family there were no supplies available to perform the dressing change. During an interview on 10/9/19 at 8:04 AM Nurse #1 stated she worked with Resident #13 on 9/21/19 and there were no supplies for his dressing change in the treatment cart and in the large supply storage room. She stated she was not aware of a smaller supplies storage area that could be accessed by the wound care nurse, but	F 684	sighted and/or require correction. F483.25 It is the intent of the facility to provide dressing changes as ordered by MD/Practitioners. Resident #13's treatment/dressing to his open blister to right shin was performed on 9/22/19 and as MD ordered thereafter. Resident #13's open blister to right shin was healed on 10/8/19. On 10/21/19 a 100% audit was completed by the treatment nurse of all other resident's with skin integrity issues/wound orders to make sure that the MD orders were being followed as ordered. The treatment nurse/designee will monitor the TAR's daily at clinical meeting for signature that the treatment was completed as ordered or/and wound care protocols. Staff education/in-service was completed on 9/16, 18, 19, 20, 21, /19 re: "treatments must be completed as ordered by the MD/practitioners." "treatments must be completed by the charge nurses on the week-ends and if the supplies are not available the DON or MD must be notified for needed supplies and/or new MD orders." The facility will continue to order supplies each Monday.	

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F 684	Continued From page 2 she did not believe she would have been able to get in to that room even if she had known about it because no one in the facility that Saturday had the key. The nurse further stated she informed the family at the bedside that the wound treatment was not done for this reason. The nurse concluded she did not notify the physician or do anything further with the dressing because it was clean and dry and dated 9/19/19. During an interview on 10/9/19 at 9:42 AM Physician #1 stated if a resident had a dressing change ordered and the supplies were not available to the nurse, the nurse should either notify her or the on call physician or nurse practitioner to inform them of the situation and see if there could be an alternative they could implement until the supplies were available again. She further stated she was not aware of the missed dressing change for Resident #13. During an interview on 10/9/19 at 10:27 AM the Director of Nursing stated for Resident #13 on 9/21/19 the first thing Nurse #1 should have done was call the physician or on call physician and gotten an alternative dressing order to perform the dressing change due that day until the supplies were available again. She further stated the second thing Nurse #1 could have done was to call her as the Director of Nursing to receive guidance on what could be done to perform the dressing change as ordered. The Director of Nursing stated she would have come to the facility to give her access to the smaller supply closet which the nurse was unaware of at that time and she could have educated her.	F 684	The charge nurses will make the treatment nurse or DON aware of needed supplies on a weekly basis each Friday. The treatment nurse will continue to alert the DON weekly of needed supplies by 12:00PM each Monday for order submission. Delivered treatment supplies will be place in the master supply closet each Thursday. The treatment nurse/designee will stock the treatment cart weekly on Fridays and as needed. Any Identified problems will be reported to the QI Committee. The QI Committee will monitor the data weekly times 1 month, monthly times 3 months and then randomly. Any identified problems will be corrected immediately to maintain compliance.	