

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

PRINTED: 02/04/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/03/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-NEUSE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1303 HEALTH DRIVE</b> <b>NEW BERN, NC 28560</b>	
(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 000	INITIAL COMMENTS  A complaint investigation survey was conducted from 01/02/20 through 01/03/20. Event ID# 2V7Q11. One of the 4 complaint allegations was substantiated resulting in a deficiency.	F 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 record reviews, observations, staff, and physician interviews, the facility failed to follow physician orders for 2 of 3 residents reviewed for wound care (Resident # 2 & 4).  Findings included:  1. Resident #2 was admitted to the facility on 3/12/19 with reentry on 6/04/19 with diagnoses which included diabetes mellitus and chronic obstructive pulmonary disease.  Review of Resident #2's medical record revealed the Physician had written an order dated 12/09/19 that read Cleanse left calf with normal saline. Pat dry. Apply hydrogel and cover with alginate. Cover with island dressing daily.  During an observation of wound care for Resident #2 on 1/03/20 at 9:27 AM, Nurse #1 removed the old dressing on the left calf, cleaned the wound with normal saline, patted the wound dry, applied	F 658	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.  "Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;  The physician was notified about Resident #2's wound care orders and the order was changed to the treatment recommended by the wound care company and that was provided but Nurse #1 on January 3rd, 2020. The order for Resident #4 was corrected to 125mm/hg on January 3rd, 2020.	1/31/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/20/2020

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 658	<p>Continued From page 1</p> <p>Santyl ointment to open area, covered wound with alginate, and covered the alginate with an island dressing.</p> <p>During an interview with Nurse #1 on 1/03/20 at 12:30 PM she stated the wound care physician had recommended Santyl be used on Resident #2's left calf wound, and it was on the wound care consult notes dated 12/02/19. She also stated the order should have been changed to reflect the wound care physician's recommendations, but the order had not been changed. She further stated it was an oversight that the wound care orders had not been changed.</p> <p>During an interview with the Director of Nursing (DON) on 1/03/20 at 2:39 PM, she stated the facility staff should follow physician orders for resident care and update orders as recommended by consultants.</p> <p>During an interview with the Physician on 1/03/20 at 1:56 PM, he stated he expected staff to follow orders and change orders as needed to accurately reflect recommendations.</p> <p>During an interview with the Administrator on 1/03/20 at 3:23 PM she stated staff should follow physicians' orders or contact the physician to get the orders changed as needed for resident care and she did not know why this had not been done for Resident #2.</p> <p>2. Resident #4 was admitted to the facility on 12/13/19 with diagnoses which included diabetes mellitus, anxiety and depression.</p> <p>Review of Resident #4's medical record revealed the Physician had written an order dated 12/18/19</p>	F 658	<p>"Address how the facility will identify other residents having the potential to be affected by the same deficient practice;</p> <p>On January 3rd and 4th, the Director of Nursing, Unit Managers and Nurse Navigator reviewed all wound orders to ensure they reflect current treatment being provided. No other issues were identified.</p> <p>"Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;</p> <p>The licensed nursing staff will be in-serviced by January 31st, 2020 about order entry verification and following physician orders. This in-servicing began on January 3rd, 2020. This education will be added to general licensed nursing orientation beginning on January 6th, 2020.</p> <p>The Director of Nursing / Nurse managers / Skin Integrity Coordinator will review the wound care notes upon completion of their wound rounds to ensure no new orders or changes are within the body of their notes weekly for 4 weeks then monthly thereafter.</p> <p>The Skin Care Coordinator will review three resident treatment orders versus treatments completed weekly for 4 weeks then monthly thereafter, the Director of Nursing will validate this audit.</p>		

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F 658	<p>Continued From page 2</p> <p>that read in part Wound Vacuum (wound vac) at 120 millimeters of mercury (mm/hg) applied to left hip wound.</p> <p>During an observation of wound care for Resident #4 on 1/03/20 at 10:17 AM, Nurse #1 turned off the wound vac, removed the old cannister, removed the old dressing on the left hip wound, cleaned the wound with normal saline, patted the wound dry, inserted a wound vac sponge into the wound, covered the left hip wound with a tegaderm (clear adhesive) dressing, applied the suction tubing seal over the tegaderm dressing, connected the suction tubing and turned the wound vac on. Nurse #1 then observed the wound vac to ensure it was functioning properly and the wound vac suction had no leaks. She confirmed the wound vac negative pressure setting was 125 mm/hg.</p> <p>During an interview with Nurse #1 on 1/03/20 at 12:30 PM she stated she was unaware the physician's order for the wound vac negative pressure setting was 120 mm/hg for Resident #4. She further stated she believed there was an entry error and the correct setting should be 125 mm/hg and not 120 mm/hg. Nurse #1 stated the normal setting for a wound vac is 125 mm/hg and that was why Resident #4's wound vac was set to 125 mm/hg instead of 120 mm/hg as ordered. She also revealed she had not contacted the physician to clarify the wound vac setting order.</p> <p>During an interview with the Director of Nursing (DON) on 1/03/20 at 2:39 PM, she stated the facility staff should follow physician orders or contact the physician to verify an order if they had any questions.</p>	F 658	<p>"Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;</p> <p>The Director of Nursing or Nurse Manager will bring the findings from these audits to the monthly Quality Assurance and Performance Improvement meetings for three months, and quarterly thereafter for one year to ensure compliance is achieved and sustained.</p> <p>"Corrective action will be complete as of January 31st, 2020.</p>		

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F 658	<p>Continued From page 3</p> <p>During an interview with the Physician on 1/03/20 at 1:56 PM, he stated he expected staff to follow orders or contact him if there was a question. He also stated he believed the wound vac order for 120 mm/hg was an entry error and needed to be corrected.</p> <p>During an interview with the Administrator on 1/03/20 at 3:23 PM she stated staff should follow physicians' orders or contact the physicians to get the orders changed as needed for resident care and she did not know why this had not been done for Resident #4.</p>	F 658		