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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345520 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 02/12/2020 |
| NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH THOMASVILLE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1028 BLAIR STREET THOMASVILLE, NC 27360 | |
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| F 000 | INITIAL COMMENTS A complaint survey was conducted from 2/11/20 through 2/12/20. 1 of the 8 complaint allegations were substantiated resulting in a deficiency at F686 and F641. | F 000 | | |
| F 641 SS=D | Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to correctly code the resident's nutritional status (section K) on the Minimum Data Set (MDS) assessment for 1 of 3 residents reviewed for nutrition (Resident #1). Findings included: Resident #1 was admitted to the facility on 8/25/18 with the diagnoses of dementia, diabetes, and protein calorie malnutrition. A dietary note dated 1/10/20 revealed the resident had a weight warning. Weight loss was planned as the resident was on diuretic therapy (Lasix) ordered 11/12/19 for 3 days. Resident #1's quarterly Minimum Data Set (MDS) dated 1/11/2020 revealed the resident was severely cognitively impaired. Section K of the MDS revealed the resident was on a physician-prescribed weight loss plan. The MDS coordinator was interviewed on 2/12/20 at 2:15 PM. She stated the lookback period was 1/5/20 to 1/11/20 for the resident's MDS dated | F 641 | 1. The deficiency occurred because the facility failed to accurately code the Minimum data set (MDS) for resident #1. MDS coordinator modified the assessment for resident #1 to reflect the correct coding on 2/28/2020. 2. Section K of the MDS, for all current residents were audited on 2/28/2020 for accuracy by the MDS Nurse /Dietary Manager. Opportunities were corrected by the MDS coordinator. . MDS Nurse/Dietary manager were re-educated by the Administrator on 2/28/2020 regarding the importance of accurately coding the MDS, specifically, nutritional status. 3. Director of Nursing (DON) will audit 5 minimum data sets per week x 12 weeks to ensure accuracy. 4. The minimum data set nurse (MDS) will report the findings of the audits and reviews to the Quality Assurance and | 3/6/20 |

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

TITLE

(X6) DATE

Electronically Signed

02/29/2020

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 641 | Continued From page 1 1/11/20. The MDS coordinator stated she didn't think Resident #1 was on a doctor's prescribed weight loss plan as indicated on the 1/11/20 MDS. She stated the dietary manger coded/completed section K of this MDS assessment. The dietary manager (DM) was interviewed on 2/12/20 at 3:02 PM. She stated she must have clicked the button on Resident #1's 1/11/20 MDS to indicate the resident was on a physician's prescribed weight loss plan due to the dietary note she read (incorrectly). The DM explained the resident had some weight loss but wasn't on a physician prescribed weight loss regimen. The Director of Nursing (DON) was interviewed on 2/12/20 at 5:09 PM. The DON stated she would expect for the MDS to be coded as accurate as possible but added sometimes people make mistakes. | F 641 | Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The MDS nurse, DON and Administrator are responsible for implementing the plan. | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced | F 686 | | 3/6/20 | |

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| F 686 | <p>Continued From page 2</p> <p>by: Based on record review and staff interviews and Nurse Practitioner and Physician (MD) interviews, the facility failed to provide treatment for an unstageable pressure ulcer on the resident's buttocks for two days for 1 of 3 residents reviewed for pressure ulcers. (Resident #1).</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility on 8/25/18 with the diagnoses of dementia, diabetes, and protein calorie malnutrition.</p> <p>Resident #1's quarterly Minimal Data Set dated 1/11/2020 revealed the resident was severely cognitively impaired. The resident had no behaviors present, including rejection of care. The resident required total dependence with bed mobility, eating, toilet use, personal hygiene and bathing. She had impairment on 1 side of her upper and lower extremities. She was always incontinent of bowel and bladder. She had no unhealed pressure ulcers but was at risk for a pressure ulcer.</p> <p>The resident had a care plan in place (revised on 8/21/19) for the risk of skin breakdown. An intervention included weekly skin observations by a licensed nurse, and to report changes to the medical doctor.</p> <p>A nursing note dated 1/10/20 at 7:42 PM written by Nurse #4 revealed the "CNA (certified nursing assistant) called writer into room at 1930 to note new, open area to (L) upper buttock during incontinent care". The resident denied pain. No active bleeding ... "Origin unknown at this time." The resident was afebrile and vital signs were</p> | F 686 | <p>Physician was notified by Director of Nursing (DON) on 1/12/20 a new wound was observed on 1/10/20 and treatment not initiated until 1/12/20, by wound care MD.</p> <p>All residents with wounds have been reviewed to ensure wound care orders in place, by DON.</p> <p>All licensed nursing staff were in-serviced by Assisted Director of Nursing(ADON)/Staff Development Coordinator(SDC) regarding policy and expectations of treatment services including not to put new wound issues in MD book but will call MD to inform and receive orders and initiate orders at time wound observed. In-service also included to call DON when wound is observed to ensure all protocols are followed. Weekly audits will be conducted by Director of Nursing/ADON with Licensed nurses to ensure any skin issues are being called to MD/NP for orders and initiated. DON/ADON will also review nurses notes to ensure skin issues are being called to MD/NP.</p> <p>The DON will report findings of audits to the quality assurance committee for any additional monitoring or modifications of the plan monthly for 3 months. The Quality Assurance and performance Improvement committee can modify this plan to ensure facility remains in compliance.</p> | |

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| F 686 | <p>Continued From page 3</p> <p>stable. The medical doctor was notified via the doctor's book (facility protocol). New preventative order in place to clean and keep area dry. Close ongoing monitoring continued.</p> <p>A weekly skin assessment dated 1/10/20 and completed by Nurse #4 stated "New unstageable open area noted this shift by CNA". The area was to the resident's left buttock. There was no documentation on the skin assessment about the resident having any skin problems on her sacrum.</p> <p>An undated and unsigned Situation, background, Assessment and Response (SBAR) form revealed the resident's change in condition was "skin wound or ulcer", which started on 1/10/20. It was unknown if this condition, symptom or sign had occurred before. Under skin evaluation, "pressure ulcer" was checked. Under testing, "other, n/a" was checked. The SBAR also revealed under "Primary care clinician notified", the document said "no". Under "recommendations of Primary Clinicians (if any): MD to notified within 24 hours via MD book per facility protocol."</p> <p>Resident #1 physician's orders from 1/10/20 through 1/12/20 revealed, no orders were written for wound care or treatment from 1/10/20 through 1/12/20 for the resident's pressure ulcer to the left buttock.</p> <p>Resident #1's Treatment Administration Record (TAR) and Medication Administration Record from 1/10/20 through 1/12/20 revealed no indication that any treatment was preformed to the pressure ulcer on the resident's left buttock.</p> | F 686 | | | |

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| F 686 | <p>Continued From page 4</p> <p>Resident #1's nursing notes from 1/11/20 through 1/12/20 revealed there was no documentation regarding the status of the resident's left buttock pressure ulcer.</p> <p>A wound assessment dated 1/13/20 revealed the resident was seen by the wound care doctor during rounds and the resident was updated on the wound's status. The resident also had an unstageable wound to her left buttock, that was 100% necrosis with a serious, moderate drainage. The wound measured 3.5 cm x 6.6 cm. The area was treated with Santyl (a debridement agent) and Dakin's solution (an antiseptic cleanser) and covered with a gauze. The date the wound was acquired was documented as 1/13/20. (Per the nursing notes, this wound was discovered on 1/10/20).</p> <p>An initial wound evaluation and management summary, written by the wound care doctor dated 1/13/20 revealed the resident had an unstageable wound to the left buttock (due to necrosis) that measured 3.5 cm x 6.6 cm. The treatment dressing plan stated to apply Santyl daily and Dakin solution once and a waterproof gauze to be applied daily for 30 days. The note also revealed that a surgical excisional debridement procedure was performed on the wound to remove necrotic tissue and establish the margins of viable tissue.</p> <p>A wound evaluation by the wound care doctor dated 1/20/20 revealed the resident presented with incontinence associated dermatitis of unknown duration. The resident had an unstageable wound to the left buttock which measured 2.8 cm x 5.5 cm x 1.1 cm and was healing. The wound underwent a debridement procedure.</p> | F 686 | | | |

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| F 686 | Continued From page 5 Nursing Assistant #1, who cared for Resident #1 on 1/10/20 from 3:00 PM to 11:00 PM was interviewed on 2/12/20 at 1:13 PM. She stated that night (1/10/20) she went to change the resident and the resident had a black mark on her buttock. The area was a little open and had a little red spot, but no drainage was present. She stated she got the nurse and the nurse told her there was nothing previously charted about the wound. NA #1 stated she thought the nurse dressed the wound that night. The NA revealed the wound to the resident's buttock was the only wound. Nurse #4 was interviewed on 2/12/20 at 11:27 AM. Nurse #4 stated on 1/10/20, she worked from 7:00 AM to 11:00 PM with Resident #1. She stated during the second shift on 1/10/20, the Nursing Assistant (NA) told her there was an area to the resident's left upper buttock. Nurse #4 stated she observed the area and the area was open but wasn't bleeding and had no drainage. She stated she used wound cleaner on the wound and applied a dry non- adhesive dressing. She stated she completed an SBAR report, incident report, called the resident's family to inform them about the area. Nurse #4 explained she informed the resident's doctor, about the open area on the resident's left buttock, by placing a note in the doctor's book. The nurse didn't recall if there was an order put in for wound care over the weekend (on 1/11/20 and 1/12/20) to treat the pressure ulcer on the resident's left buttock. She revealed the facility didn't have standing orders. She also revealed she didn't work on 1/11/20 and 1/12/20 but passed the information about the resident's left buttock wound to the oncoming night shift nurse. | F 686 | | | |

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| F 686 | Continued From page 6 Wound care nurse #1, who worked on 1/11/20 from 7:00 AM to 11:00 AM, was interviewed on 2/12/20 at 11:12 AM. She stated on 1/10/20 the floor nurse did a skin check and found Resident #1 had a new, opened unstageable area to her left buttocks. She stated she did not remember anything about the wound care for the resident's left buttock that weekend and did not see any orders/treatment in the resident's chart for wound care on 1/11/20 and 1/12/20. The wound care nurse stated on 1/13/20 she did an assessment of the resident's left buttock wound and found the wound was not open but was covered in eschar and was an unstageable pressure ulcer. She stated the bandage covering the wound was changed when the wound care doctor assessed the wound on 1/13/20 and orders for wound care were written on 1/13/20. Further interview with wound care nurse #1, on 2/12/20 at 1:56 PM revealed she did not perform all of the resident wound care treatments when she worked on Saturday (1/11/20), but the treatments she performed she would have documented on the TAR. She stated she told the nurses to check the TAR before she left for the day, so they would know which dressings she didn't perform. She didn't do Resident #1's wound care on Saturday (01/11/20) because she didn't have an order to provide treatment. Nurse #3, who worked on 1/11/20 from 7:00 PM to 7:00 AM and on 1/11/20 from 11:00 PM to 7 AM on 1/12/20, was interviewed on 2/12/20 at 1:44 PM. She stated on 1/11/20 and 1/12/20 she knew Resident #1 had wounds and thought the treatment nurse treated the resident's wound on both of these dates. She said she never saw or | F 686 | | | |

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| F 686 | <p>Continued From page 7</p> <p>treated the resident's wounds. Nurse #3 explained if the wound care nurse was not here, then the nurse on the day shift would do wound care. She stated if a new wound was discovered, they would leave a note in the doctor's book. If the new wound was discovered on a Friday or Saturday, then the nurse would call the doctor and get an order for the wound until the wound care doctor could look at the wound.</p> <p>Nurse #2, who cared for Resident #1 on 1/11/20 from 7:00 AM to 7:00 PM and on 1/12/20 from 7:00 AM to 11:00 PM, was interviewed on 2/12/20 at 4:29 PM. She stated she was unable to recall if she provided wound care treatment to Resident #1 on 1/11/20 or 1/12/20. She was also unable to recall any information about the resident's wound. She stated she would document wound care on the TAR and would put a note in as well if she performed wound care. She stated she wouldn't do a treatment change to a wound if there wasn't an order for it. She specified on 1/11/20 and 1/12/20 she never called the doctor regarding Resident #1.</p> <p>The Nurse Practitioner was interviewed on 2/12/20 at 12:22 PM. She stated Resident #1 had a wound and her health had been declining. She stated the resident would have less blood flow to her skin since she was sick, and her blood was going to her organs. She said she ordered wound care (1/13/20) and wound care consult for the resident (1/13/20). The resident had an unstageable wound and had 1 stage-able wound. The resident also had decreased nutrition and diabetes, which was controlled. She was not aware of a time that wound care was not provided to Resident #1's left buttock pressure ulcer on 1/11/20 and 1/12/20. There were no standing</p> | F 686 | | | |

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| F 686 | <p>Continued From page 8</p> <p>orders at this facility and the nurses have to call the on-call provider for any concerns.</p> <p>The Medical Director was interviewed on 2/12/20 at 3:44 PM. The Medical Director stated Resident #1's wounds were getting worse and she was being seen by the nurse practitioner and the wound care doctor. Resident #1 had a previous stroke, contractures to her arm and rarely got out of bed. The staff were trying to reposition the resident, but she stayed in 1 position. The resident was at risk for having pressure ulcers as she would not get out of bed and she would always find her lying in one spot. She stated she was not contacted on 1/11/20 or 1/12/20 about Resident #1 having a wound. If the staff saw drainage or infection to the wound, then they should call the provider on call. She would expect for the pressure ulcer to be put in the book and thought this pressure ulcer was unavoidable.</p> <p>The wound care doctor was interviewed on 2/12/20 at 4:08 PM. He stated he came to the facility on Monday mornings. The doctor stated when he saw Resident #1 on 1/13/20 the resident had 2 pressure ulcers. The bigger pressure ulcer (on the left buttocks) was grossly necrotic and needed debridement. He stated he expressed how bad the wound was to staff. He debrided the wound and used Santyl and Dakin's to treat the wound. The wound was worse the next time he saw it (1/20/20). He felt like the resident's pressure ulcers were possibly Kennedy ulcers as she had multiple comorbidities and diabetes. He stated there should have been some treatment in place (on 1/11/20 and 1/12/20) before he saw the wound (on Monday 1/13/20). The staff could always call him, and he would almost always start resident's on Santyl if the area was an</p> | F 686 | | | |

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| (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 686 | Continued From page 10 skin, which could have caused the wound. | F 686 | | |