

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345406	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/06/2020
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 38 CARTERS ROAD GATESVILLE, NC 27938		
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F 000	INITIAL COMMENTS An on-site complaint investigation survey was conducted on 11/3/20 through 11/4/20 in conjunction with a revisit (Event ID #S8C112). The survey was extended to 11/6/20 for the completion of interviews. Event ID # ONPP11. One (1) of 1 allegation was substantiated with a citation identified at F686.	F 000			
F 686 SS=E	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 by: Based on record reviews and staff and physician interviews, the facility failed to document and/or provide 9 of 21 pressure ulcer treatments in accordance with a physician ' s order for 1 of 1 resident (Resident #1) reviewed for pressure ulcers. The findings included: Resident #1 was admitted to the facility on 7/26/17 with re-entry from a hospital on 3/3/20.	F 686	Resident #1 was discharged to the hospital on September 10th, 2020 and has not returned to the facility. Other residents at risk: Residents with skin impairments which require treatments in accordance with physician orders are at risk for the same deficient practice. Systemic measures implemented to	12/8/20	

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

TITLE

(X6) DATE

Electronically Signed

12/03/2020

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 686	<p>Continued From page 1</p> <p>His cumulative diagnoses included anoxic brain damage, chronic kidney disease, diabetes, atrial fibrillation (a type of heart arrhythmia), congestive heart failure, and quadriplegia.</p> <p>The resident ' s most recent Minimum Data Set (MDS) was a quarterly assessment dated 7/21/20. The MDS revealed Resident #1 had severely impaired cognitive skills for daily decision making. No behaviors nor rejection of care were reported. Resident #1 required extensive to total assistance with all Activities of Daily Living (ADLs), with the exception of being independent with eating after receiving set up help only. He was frequently incontinent of bladder and always incontinent of bowel. Section K of the MDS reported the resident was 70 inches tall and weighed 287 pounds. He was assessed to be at risk for developing pressure ulcers, but did not have a pressure ulcer at the time of the MDS assessment.</p> <p>A review of the resident ' s most recent care plan included an area of focus which indicated the resident had potential impairment to skin integrity related to diabetes, obesity, poor mobility, and incontinence (Initiated and Revised on 3/3/20). The planned interventions for this area of focus included, "Wound care to open area on back per MD (Medical Doctor) orders" (Date Initiated 8/21/20). Resident #1 ' s care plan also addressed his refusal to get out of bed as well as refuse daily cares with an increased risk for complications related to these behaviors (Initiated on 3/3/20; Revised on 7/25/20).</p> <p>Resident #1 ' s medical record included a Weekly Skin Review dated 8/15/20 and completed by Nurse #1. The nurse reported the resident ' s</p>	F 686	<p>ensure the same deficient practice does not re-occur include:</p> <p>" On November 3rd and 4th, 2020 current residents with skin impairments treatment administration records (TARs) were reviewed by the Director of Nursing to ensure treatments were being provided as ordered. Negative findings were addressed if noted.</p> <p>" Current licensed nurses were educated by the Director of Nursing/designee regarding providing treatments as ordered and signing the TAR (treatment administration record) once the treatment was provided. The education was completed on December 3rd, 2020. This education will be provided to newly hired licensed staff and agency staff by the Director of Nursing/designee during the orientation period.</p> <p>" During the morning clinical meeting the TARs of 5 residents with skin impairments will be reviewed by the Director of Nursing/designee to ensure treatments were provided. The TAR audits will be conducted daily times 2 weeks then weekly times 2 weeks and monthly times 2 months. Negative findings will be addressed when/if noted.</p> <p>Quality Assurance: The results of all audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for 3 months to determine the effectiveness of this plan.</p>		

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F 686	<p>Continued From page 2 skin was intact at that time.</p> <p>A review of a facility Incident Report dated 8/20/20 and completed by Nurse #2 revealed a pressure ulcer was reported for Resident #1 "at back surgery area" with a "small place open up." The nurse documented the immediate action taken was to apply Duoderm to the area. Duoderm is a type of wound dressing with gel-like properties.</p> <p>A Physician ' s Order was received on 8/20/20 for Duoderm to be applied to the area on the resident ' s lower back (at the old surgical line), and to cleanse and change the dressing every 3 days on day shift. The start date for this order indicated the next application of the Duoderm was scheduled for 8/23/20.</p> <p>A Weekly Skin Review dated 8/23/20 documented the resident had a small opening with surrounding redness and minimal swelling at the base of his back.</p> <p>A review of Resident #1 ' s August 2020 Treatment Administration Record (TAR) revealed the Duoderm was applied to the pressure ulcer on 8/23/20 and 8/26/20 as ordered by the physician.</p> <p>A Weekly Pressure Wound Observation Tool was completed by Nurse #3 on 8/26/20. This tool reported Resident #1 ' s sacral pressure ulcer was acquired on 8/20/20 and noted to be a Stage 2 pressure ulcer. The extent of necrosis and/or slough in the wound bed was 5 percent (%). The wound measurements were: 2 centimeters (cm) in length; 2 cm in width; and 1 cm in depth.</p>	F 686	<p>Additional interventions will be developed and implemented by the Committee to ensure sustainability of substantial compliance.</p>		

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F 686	<p>Continued From page 3</p> <p>An encounter with Resident #1 was performed and documented by his Medical Doctor (MD) on 8/26/20 at 10:05 AM. Upon physical exam, the MD reported the resident had an elongated quarter-sized pressure ulcer with a small area of eschar on his sacral area. The Assessment / Plan reported Resident #1 would be treated with a medication on an everyday basis.</p> <p>A physician ' s order was received on 8/26/20 to discontinue the Duoderm and initiate 250 units/gram Santyl ointment (a topical medicine that removes dead tissue from wounds) with a start date of 8/27/20. Instructions indicated the Santyl ointment should be applied to his sacrum topically every day shift; cleanse with normal saline and cover with dry dressing until healed.</p> <p>A review of Resident #1 ' s August 2020 Treatment Administration Record (TAR) documented wound care treatment with Santyl ointment was completed once daily from 8/27/20 through 8/31/20 in accordance with the physician ' s orders.</p> <p>A Weekly Pressure Wound Observation Tool was completed by Nurse #3 on 8/31/20. This tool reported the resident ' s MD had previously seen the resident ' s wound on rounds. Documentation indicated Resident #1 ' s sacral wound continued to be a Stage 2 pressure ulcer but the overall impression of the wound was noted as, "worsening." The extent of necrosis and/or slough in the wound bed was 5 %. The wound measurements were: 6 cm in length; 6 cm in width; and 4 cm in depth. The evaluation of wound progress was noted as, "not good."</p> <p>An encounter with Resident #1 was performed</p>	F 686			

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F 686	<p>Continued From page 4</p> <p>and documented by his MD on 9/2/20 at 9:12 AM. The History of Present Illness (HPI) reported the resident had eschar to his sacral area about the size of a quarter. The MD documented, "He (Resident #1) doesn ' t like to get out of his bed and his wound has significantly expanded." The Assessment / Plan also reported the resident had a significant progression of the wound from the previous week. The MD indicated wound care treatment with Dakin ' s solution (a topical medication used to prevent and treat skin and tissue infections) would be initiated.</p> <p>A physician ' s verbal order was received and input into the electronic medical record by Nurse #4 on 9/2/20 at 2:26 PM to initiate Dakin ' s (1/4 strength) solution with instructions to apply the solution to Resident #1 ' s sacral area topically every shift (twice daily) for wound treatment. The order ' s start date was designated as 9/2/20 on night shift 6:00 PM - 6:00 AM. A revision to the order was input into the electronic medical record by Nurse #4 on 9/2/20 at 2:37 PM. The revision indicated a verbal order was received from the MD for Dakin ' s (1/4 strength) solution with instructions to apply the solution to Resident #1 ' s sacral area topically three times a day for wound treatment. The start date for the new order was designated in the computer system as 9/3/20 at 10:00 PM. Once daily use of the Santyl ointment was continued.</p> <p>A review of Resident #1 ' s September 2020 Treatment Administration Record (TAR) documented wound care treatment with Dakin ' s (1/4 strength) solution was scheduled to be done at 5:00 AM, 2:00 PM and 10:00 PM every day. However, this treatment was not initiated nor documented as completed on 9/2/20 at 10:00</p>	F 686			

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F 686	<p>Continued From page 5</p> <p>PM, 9/3/20 at 5:00 AM, or 9/3/20 at 2:00 PM. The first documented wound treatment of Dakin ' s solution on the TAR was initialed as completed on 9/3/20 at 10:00 PM. Further review of the resident ' s TAR revealed the following:</p> <p>--Wound treatment scheduled for 9/4/20 at 5:00 AM was initialed by Medication (Med) Aide #1 with a code which indicated, "Other / See Nurse Notes." Review of a Medication Administration Note for the Dakin ' s Solution dated 9/4/20 at 6:11 AM and authored by Nurse #7 read, "nurse aware."</p> <p>--Wound treatment was not initialed to indicate it was done as scheduled on 9/5/20 at 2:00 PM;</p> <p>--Wound treatment scheduled for 9/5/20 at 10:00 PM was initialed by Med Aide #1 with a code which indicated, "Sleeping."</p> <p>--Wound treatment scheduled for 9/6/20 at 5:00 AM was initialed by Med Aide #1 with a code which indicated, "Sleeping."</p> <p>--Wound treatment was not initialed to indicate it was done as scheduled on 9/7/20 at 10:00 PM;</p> <p>--Wound treatment was not initialed to indicate it was done as scheduled on 9/8/20 at 5:00 AM.</p> <p>An encounter with Resident #1 was performed and documented by his MD on 9/9/20 at 7:46 AM. The History of Present Illness (HPI) reported the MD was asked to see and evaluate Resident #1. The MD reported the resident was progressively going downhill and was not conversant at the time of the evaluation. His physical examination noted the resident ' s sacral area had a 15 x 12 cm chronic decub (pressure ulcer) with a small amount of drainage. He noted one could palpate the bone directly underneath the skin; the resident did not appear to have any muscle layer there. The MD ' s Assessment / Plan reported Resident #1 had increased lethargy with</p>	F 686			

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F 686	<p>Continued From page 6 progression of a Stage 4 pressure ulcer.</p> <p>A Weekly Pressure Wound Observation Tool was completed by Nurse #3 on 9/9/20. Documentation indicated the MD saw Resident #1 ' s pressure ulcer during his rounds. The extent of necrosis and/or slough in the wound bed was 75 % and reported to be black and necrotic. The evaluation of the wound progress was noted as, "worsening sent to hospital."</p> <p>Resident #1 was sent out to the hospital for evaluation and treatment on 9/9/20 for suspected sepsis.</p> <p>A telephone interview was conducted on 11/5/20 at 1:28 PM with Nurse #1. Nurse #1 was identified as having completed the Weekly Skin Assessment for Resident #1 on 8/15/20 when his skin was intact. Upon inquiry, the nurse stated she would have noted if the resident ' s skin was even reddened at that time and it was not.</p> <p>A telephone interview was conducted with Nurse #2 on 11/5/20 at 2:05 PM. Nurse #2 was identified as the nurse who first identified an area of concern on Resident #1 ' s sacral area on 8/20/20. The nurse recalled notifying Resident #1 ' s Responsible Party (RP) about the small pressure area on his sacrum when it was initially found, which she described as being about the size of a pencil eraser. The RP reported he had previously had surgery on that area of his back. Upon inquiry, the nurse stated the resident liked to lay flat on the bed. She reported if staff tried to use pillows to re-position him, he would snatch the pillows out and throw them on the floor.</p> <p>An interview was conducted on 11/4/20 at 11:10</p>	F 686			

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F 686	<p>Continued From page 7</p> <p>AM with Nurse #3. Nurse #3 was identified as the wound treatment nurse. During the interview, the wound treatment nurse reported she was typically the individual who completed wound measurements weekly on residents ' pressure ulcers.</p> <p>A telephone interview was conducted on 11/5/20 at 2:40 PM with Nurse #4. Nurse #4 was identified as the nurse who input initiation of Dakin ' s (1/4 strength) solution into the electronic medical record (EMR). He recalled a few minutes after he had input the orders for the Dakin ' s solution into the computer, the physician decided it would be better to change the order from twice daily application to three times a day. The nurse reported he did the first treatment with Dakin ' s solution on 9/2/20 at approximately 2:30 PM, then revised the order in the EMR to change the frequency of the Dakin ' s solution treatment from two to three times daily in accordance with the MD order. Nurse #4 reported he was not aware the start time for the order in the EMR was 9/3/20 at 10:00 AM. He confirmed the treatments were intended to be started on 9/2/20. Upon further inquiry, the nurse recalled the facility had two bottles of Dakin ' s solution in stock on 9/2/20 at the time the order was initiated for Resident #1. The Dakin ' s solution was readily available for use within the facility.</p> <p>An interview was conducted on 11/4/20 at 1:17 PM with Medication (Med) Aide #1. Med Aide #1 was identified as documenting on Resident #1 ' s TAR three times from 9/3/20 to 9/9/20. During the interview, the med aide stated she would not purposefully document on a resident ' s TAR for wound treatments. When specifically asked, the Med Aide reported she did not complete Resident</p>	F 686			

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F 686	<p>Continued From page 8</p> <p>#1 ' s skin treatments.</p> <p>Multiple unsuccessful attempts were made to contact Nurse #7 for a telephone interview. Nurse #7 was identified as the nurse assigned to care for Resident #1 at the time his wound care treatment was scheduled to be completed on 9/4/20 at 5:00 AM.</p> <p>Nurse #5 was identified as having been assigned to care for Resident #1 on 9/5/20 at 2:00 PM. No documentation of the resident ' s wound care was initialed as having been completed on that date/time. Nurse #5 was not available to be interviewed.</p> <p>A telephone interview was conducted on 11/5/20 at 3:53 PM with Nurse #6. Nurse #6 was identified as having been assigned to Resident #1 ' s hall on 9/7/20 at 10:00 PM and 9/8/20 at 5:00 AM when his wound care treatments were scheduled. No documentation of the resident ' s wound care was initialed as having been completed on those dates/times. During the interview, the nurse could not recall whether or not she had done wound care treatments for Resident #1. She reported if she had done a skin treatment, she thought she would have documented completion of the treatment on the resident ' s TAR. However, a signed statement provided after exit from the facility indicated Nurse #6 reported wound care treatments were completed for Resident #1 on these dates/times.</p> <p>An interview was conducted on 11/4/20 at 11:20 AM with Resident #1 ' s MD. During the interview, the MD recalled seeing the resident on 8/26/20 and stated, "He definitely didn ' t want to get moving ...Told him straight up he was a ' "</p>	F 686			

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F 686	<p>Continued From page 9</p> <p>bump on a log ' and if he didn ' t get moving the wound would get worse." He reported Resident #1 only wanted to watch TV and lay on his back in the bed. He also explained that wounds could go really fast in this scenario and it was inevitable because of his lack of doing anything and getting off of the wound. The MD reported he had 30 years of experience and took care of any wound care needed for residents within the facility. The MD stated had planned to debride Resident #1 ' s pressure ulcer on 9/9/20, but he was sent out to the hospital due to possible sepsis.</p> <p>A follow-up telephone interview was conducted with the resident ' s MD on 11/6/20 at 8:30 AM. During the interview, the MD was asked what his thoughts were with regards to Resident #1 ' s pressure ulcer treatment with Dakin ' s solution being delayed and not documented and/or provided in accordance with the orders. The MD responded by stating, "The facility must have missed it." However, he reported a delay in its initiation or having missed treatments with the Dakin ' s solution would not have made a difference as to whether or not the resident did better.</p> <p>An interview was conducted on 11/4/20 at 1:29 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported she would not expect there to be "holes" (missing documentation to indicate a treatment was completed) in a resident ' s TAR. If there were holes on the TAR, she would expect documentation to explain the reason for them. When asked, the DON also reported physician orders needed to be followed, stating, "Whatever the doctor says verbatim ...needs to be put into effect."</p>	F 686			

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