STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS REHABILITATION AND CARE CENTER	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

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E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted 10/19/22-10/21/22. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# 1UR211	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted 10/19/22-10/21/22. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event ID# 1UR211 NC000192233 was investigated. The only complaint allegation was unsubstantiated. The statement of deficiency was issued late due to a State server maintenance problem.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		12/4/22

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

Electronically Signed | 11/15/2022

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F 580	Continued From page 1 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the	F 580	How the corrective action(s) will be	

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F 580	Continued From page 2 staff, Nurse Practitioner, Medical Director, the facility failed to notify the resident's Physician or Nurse Practitioner of a change in skin integrity when Resident #1 was noted to have a pressure ulcer on his buttock for 1 of 2 residents reviewed for pressure ulcers (Resident #1). The findings included: Resident #1 was admitted to the facility on 4/29/22. His diagnoses included in part, peripheral vascular disease (PVD), diabetes and osteomyelitis of his left foot wound. A verbal physician order for a dressing change was entered on 06/10/22 by the Wound Care Nurse for Resident #1. It was documented as being given by the Medical Director. The order indicated instructions for a right buttock dressing; to clean with normal saline or wound cleaner, pat dry, apply calcium alginate with silver, cover with a dry dressing daily and as needed (PRN). Record review of an Interdisciplinary Team (IDT) wound, and skin assessment note on 06/10/22 indicated the left buttock wound was cleaned with wound cleaner, patted dry and treatment applied per treatment order. It stated the physician and Responsible Party (RP) were aware of the treatment plan. Resident #1 was his own RP. The Wound Care Nurse weekly Wound Report log revealed: 06/15/22 indicated a pressure ulcer (PU) on the buttock for Resident #1. It measured 1.5 centimeters (cm) long (L) x 2.0 cm Wide (W) x 0.1 cm deep (D). An interview conducted with the Nurse	F 580	accomplished for those residents found to be affected by the deficient practice: Resident #1 was admitted to the facility on 04/29/2022 and was discharged 08/12/2022 prior to the date of survey. As the record is closed there is no way to correct the alleged deficit practice for resident #1. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents with wounds would have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The wound nurse as well as nursing staff will receive education on providing the attending physician, nurse practitioner and wound physician (if on case load) notification of change in condition specific to wounds. In addition, the weekly wound report has been updated to reflect the wound nurse's notification of all 3 disciplines (if applicable). Effective 11/10/2022, the weekly wound report will be signed by the attending physician and nurse practitioner. This education will be provided to the wound nurse by the Director of Nursing on 11/10/2022. This education on providing the attending physician, nurse practitioner and wound physician (if on case load) notification of change in condition specific to wounds will	

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F 580	Continued From page 3 Practitioner (NP) on 10/20/22 at 12:33 PM revealed she stated she was not notified of a pressure ulcer on Resident #1's buttocks in June 2022. She was asked if she would have expected to be notified of a new pressure ulcer and she stated the facility Wound Care Physician managed wounds weekly. She was informed by the Surveyor the facility Wound Care Physician did not follow him due to the resident being scheduled to go to an Outpatient Wound Care Center. The NP said this was a concern and if the facility Wound Care Physician did not follow him, she should have been informed of the new pressure ulcer. She repeated she had understood all residents were seen by the facility Wound Care Physician if needed. The NP noted she was wound certified and would have monitored it, if she had known there was a wound there. A phone interview was completed with the Medical Director on 10/20/22 at 3:49 PM regarding the pressure ulcer for Resident #1. The Physician was asked about the verbal order from the wound nurse that was entered from him for the new wound dressing on 6/10/22. He said these verbal orders were not something the nurse had to come to him with, and he would sign off on them when he was in the facility. He further stated he was not aware of the sacral pressure ulcer or the orders. An interview was conducted with the Wound Nurse on 10/19/22 at 12:10 PM. She stated she did not notify the facility physician or NP when the pressure ulcer was identified but entered orders for the wound care and they signed off on them. An interview with the DON on 10/20/22 at 5:30	F 580	be provided to Nursing staff by the Director of Nursing and/or ADON by 12/04/2022. MD/Nurse Practitioner will be educated to review weekly wound report and provide signature of acknowledgement by DON on 11/10/2022. A weekly wound report will be utilized as a tool that the physician/nurse practitioner will use to review and provide signature of acknowledgement. How the facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing and/or designee will audit weekly times 4 weeks the wound report for MD/Nurse Practitioner signature of acknowledgement. This information will be tracked and trended for compliance and the results will be presented to the Quality Improvement Committee. Continued monitoring will be decided by the members of Quality Assurance Process Improvement Committee at that time. Date of Compliance: 12/04/2022	

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F 580	Continued From page 4 PM regarding Resident #1's pressure ulcer revealed said she would have expected the NP or physician on his case would be notified of the pressure ulcer and with changes. The Administrator was interviewed on 10/21/22 at 4:04 PM via phone regarding Resident #1's the pressure ulcer concerns. He stated he expected notification to be done of the occurrence and worsening to the providers.	F 580		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements	F 661		12/4/22

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F 661	Continued From page 5 that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record reviews, Nurse Practitioner, Home Health, family and staff interviews the facility failed to send an accurate discharge summary for the resident to the Home Health agency that included a stage 4 sacral pressure ulcer. This resulted in a delay of the recommended wound care after discharge when the Home Health staff were not aware of the severity and size of the wound, for 1 of 1 resident reviewed for discharge care. Findings included: Resident #1 was admitted to the facility on 4/29/22. The Quarterly Minimum Data Set (MDS) assessment was completed on 07/30/22. It noted he did not have any unhealed pressure ulcers or injuries. Resident #1 was assessed to have moderate cognitive impairment. The End of Stay MDS assessment completed on 08/11/22 indicated Resident #1 had no unhealed pressure ulcers or injuries. A Discharge Summary progress note dated 08/11/22 completed by the Nurse Practitioner (NP) noted Resident #1 had a chronic ulcer on	F 661	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: Resident #1 was admitted to the facility on 04/29/2022 and was discharged 08/12/2022. As the record is closed there is no way to correct the alleged deficit practice for resident #1. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents with wounds would have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: MD/Nurse Practitioner will be educated how to complete an accurate discharge summary on 11/10/2022 that will include resident follow up care post discharge pertaining to actual site of a wound and specific care instructions by the Director of Nursing. Nursing Staff will be educated on how to complete an accurate discharge summary by the Assistant Director of Nursing by 12/04/2022 that will include resident follow up care post discharge pertaining to the actual site of a wound and specific care instructions.	

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F 661	Continued From page 6 his left foot. Under the skin assessment she indicated Resident #1 had a Vacuum Assisted Closure (VAC) on his left foot, eschar (black dead tissue) on his right great toe, dressings on the left elbow and bilateral heels, a right elbow scab with mild peri-wound erythema, dry scaling skin of his bilateral upper extremities and no foul odor to wounds. There was no notation regarding the large pressure ulcer to his sacrum. In the medication list, it was noted Santyl 250 unit/gram topical ointment- apply as directed to affected area once a day to sacrum. An interview was done with the Nurse Practitioner on 10/20/22 at 12:33 PM regarding the sacral pressure ulcer for Resident #1. She stated she was unaware of a sacral wound, and she did not usually look at the skin, as the facility wound care physician managed it weekly. Review of the August 2022 Treatment Administration Record (TAR) indicated the sacral dressing ordered daily with Santyl Ointment (a medication to remove dead tissue from wounds for healing) was last completed on 08/11/22. The last wound measurement note dated 08/11/22 and completed by the Wound Care Nurse noted the sacral wound to be worsening, have slough tissue present (yellow, tan, white, stringy), necrotic tissue present (black, brown, leather, scab-like), 70% black, 20% slough. It measured 14.2 centimeters (cm) in length, 8.5 cm wide, no depth was recorded. The wound progress was noted as 'deteriorated.'	F 661	Social Worker will be educated on how to complete an accurate discharge summary on 11/10/2022 that will include resident follow up care post discharge pertaining to actual site of a wound and specific care instructions by the Director of Nursing. The nursing staff will be utilizing a discharge instruction form to capture a recapitulation of the resident stay and final summary pertaining information that reflects an accurate wound site and care instructions that will be reviewed and sent with resident/family upon discharge. How the facility plans to monitor its performance to make sure that solutions are sustained: DON/ADON/member of IDT will begin audit on 11/10/2022 for each discharge per occurrence in clinical meeting prior to the date of discharge for accuracy for follow up care post discharge pertaining to actual site of a wound and specific care instructions. The audit information will be tracked and trended by the Director of Nursing and/or designee and presented to the Quality Assurance Performance Improvement (QAPI) committee. The QAPI committee will decide if further monitoring is required. Date of Compliance: 12/04/2022	

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F 661	Continued From page 7	F 661		

Resident #1's diagnoses at discharge (8/12/22) from the facility included in part, peripheral vascular disease (PVD), diabetes, atrial fibrillation, left foot wound, osteomyelitis of the left foot wound, right foot wounds and a recent COVID infection. The diagnosis list did not include the sacral pressure ulcer.
The Discharge Instruction Form for Resident #1 with an effective date of 08/12/22 at 10:52 AM indicated in part, a physician order for 'discharge home (ALF) with family with Home Health Registered Nurse (HHRN) for wound disease.'

During a phone interview on 10/20/22 at 9:19 AM with a family member, it was stated that Resident #1 was discharged to his previous assisted living facility on 08/12/22 with home health services and other caregivers were to be set up by the family. The family member said the resident wanted to go his home and they were setting up resources to accomplish that.

A phone interview was done with Home Health Nurse #1 on 10/21/22 at 1:36 PM. She noted she saw Resident #1 for his home health admission over the weekend on his second day home on 08/14/22, and there was nothing on his paperwork about a sacral wound. She stated the family told her to look at his backside and the family assisted him to stand up from the chair. She said the wound odor was overwhelming with the dressing intact. She added the wound was the size of her hand, a stage 4 (most severe), very deep and the top was a thick flap. The nurse noted she dressed the wound the best she could, but she did not have all the dressing supplies she needed, as the discharge summary

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F 661	Continued From page 8	F 661		

had nothing noted about a sacral wound. She stated his vitals were stable when she assessed him, and she had planned to call the physician the next day as he needed a surgical consult.

A Family Member was interviewed via phone on 10/20/22 at 9:19 AM regarding Resident #1's care. The family member was very upset that the facility had discharged him without the information needed for Home Health to provide care. She noted the facility had been given several days to plan the discharge. The Family Member said the Home Health nurse visited on 08/14/22 and was not aware of the wound on his backside as it wasn't in the paperwork. The family member said the wound smelled terrible and the nurse did not have the required supplies to care for it.

A phone interview was conducted with the Administrator on 10/21/22 at 3:55 regarding the discharge summary. He stated he would have expected that the Provider would have information under the skin section about all the wounds, including the pressure ulcer. He said this should be done to provide the Home Health agencies, with a snapshot of what the resident's needs might be.