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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING ______ B. WING ______	C **01/28/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	**128 SNOW HILL ROAD** **AYDEN, NC 28513**

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F 000	INITIAL COMMENTS A complaint investigation was conducted on 1/26/2023 through 1/28/2023. Four of the eleven allegations were substantiated resulting in deficiencies for three of the eleven allegations. Intake #'s NC00197054, NC00197191, NC00197505, NC00195853, NC00195101. Event ID # KNUA11	F 000		
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 by: Based on observation, record review, resident interview, and staff interview the facility failed to provide services to treat and prevent pressure sores for one (Resident # 7) of three sampled residents reviewed for pressures sores. The facility failed to assure Resident # 7 was positioned off her catheter tubing and catheter tubing clamp which contributed to her developing a pressure sore. The facility also failed to assure there was follow up when her specialty air mattress was malfunctioning. The findings	F 686		

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

Electronically Signed

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	Continued From page 1	F 686		

included:

Resident # 7 was admitted to the facility on 2/22/22. Resident # 7 had diagnoses which in part included a progressive neurological disease, a stroke, paraplegia (paralysis of the legs), and suprapubic catheter placement secondary to neuromuscular dysfunction of the bladder.

Resident # 7 ' s quarterly Minimum Data Set Assessment, dated 11/23/22, coded Resident # 7 as cognitively intact and as needing extensive assistance with her bed mobility. She was also assessed to have pressure sores.

Resident # 7 ' s care plan, dated 11/23/22, noted Resident # 7 at times refused to be properly positioned and she was being treated for pressure sores. The care plan noted Resident # 7 had a specialty mattress. Resident #7 ' s NA ' s (Nurse Aide ' s) current care guide noted Resident # 7 needed extensive assistance for her hygiene and bathing needs. It also noted she had an indwelling catheter and the NAs were directed on the care guide to ensure that the drainage tubing was secured with an anchoring device.

On 1/26/23 at 5:16 PM the treatment nurse made the following notation in the medical record. "New skin issue found when skin assessed. Cath line was running under resident ' s R (right) leg. She was lying on it and the clip of it. It left purple bruising, erythema and a fluid filled blister to outer R (right) knee/calf area. This is a stage 2 injury. Area was skin prepped and covered with foam dressing. (RP) and MD notified."

On 1/27/23 at 9:45 AM the treatment nurse was observed as she cared for Resident # 7 ' s

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F 686	Continued From page 2 pressure sores. Resident # 7 was observed to have a red blister area to the lateral part of her right leg near the knee area. According to the treatment nurse, she had found Resident # 7 laying on the clamp part of her catheter tubing the previous day. Resident #7 stated she had not realized she had been left lying on the tubing and clamp when the staff had positioned her because she could not feel it. During the pressure sore observation on 1/27/23 at 9:45 AM, it was also observed that Resident # 7 did not move her legs as she was positioned for the care. It was also observed that Resident # 7 ' s specialty air mattress was turned off. The treatment nurse did not know why it had been turned off and was observed to turn it back on prior to leaving the room following wound care. On 1/28/23 at 8:45 AM Resident # 7 was observed in bed with the specialty air mattress turned off again. This was brought to the attention of Nurse # 2 (a nursing supervisor) at that time. Nurse # 2 stated she did not know why the mattress was off. Resident # 7 stated the staff had turned it off in the middle of the night. Resident # 7 thought it was beeping before the staff turned it off. On 1/28/23 at 8:55 AM the treatment nurse was interviewed again. She was unaware the air mattress had been turned off or that there was a problem with it. She reported that if there was a problem with the mattresses then maintenance would check them. During this interview, the treatment nurse also confirmed that Resident # 7 should not have been left lying on her catheter tubing and clamp, but she felt the Stage 2 pressure area/blister would heal quickly with treatment.	F 686		

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F 686	Continued From page 3 On 1/28/23 at 9:00 AM the treatment nurse reported she had followed up about the air mattress and there was a problem with it which she would get maintenance to check and resolve, but it had not been brought to her attention before the morning of 1/28/23 so that she could have alerted maintenance earlier. On 1/28/2023 at 10:08 AM the DON (Director of Nursing) was interviewed. According to the DON, Resident # 7 should not have been left lying on her catheter tubing. She also was not aware why Resident # 7 ' s specialty mattress had been turned off on two consecutive days.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure a resident did not fall from bed while care was being rendered. This was for one (Resident # 2) of three residents reviewed for accidents. The findings included: Record review revealed Resident # 2 resided at the facility from 9/27/18 until 1/16/23. The resident ' s diagnoses included in part a history of stroke, a progressive neurological disease, and	F 689		

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F 689	Continued From page 4 contractures of both knees. Resident # 2 ' s Minimum Data Set Assessment (MDS), dated 12/26/22, coded the resident as cognitively intact. He was assessed to need extensive assistance from two staff members for bed mobility and was totally dependent on staff for his hygiene and bathing needs. He was not assessed as having experienced falls since the last MDS assessment. Physical therapy documentation, dated 10/3/22, noted Resident # 2 required total assistance for his bed mobility. Under "functional deficits/mobility," the therapist had noted the following regarding Resident # 2 ' s ability to roll left and right. "Dependent-Helper does all of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity." Resident # 2 ' s care plan, dated 12/22/22, noted the resident was a paraplegic (paralysis of the legs). The care plan also noted Resident # 2 was at risk for falls. Resident # 2 ' s CNA (Certified Nursing Assistant) care guide noted Resident # 2 needed the assistance of one person to provide extensive assistance for his bathing needs. Under "special precautions," the care guide noted "falls." On 1/15/23 at 9:49 PM Nurse # 1 noted the following. "Resident found on the floor of room beside his bed. He was laying on his back. Assessment completed. Patient has R (right) sided weakness. R hand grip weak. Bleeding noted on his right outer leg. Patient has a dressing on his right inner leg and an open area above his bottom. He denies any pain. Patient is	F 689		

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F 689	Continued From page 5 alert and oriented X 3. PERRLA (Pupils are equal, round, and reactive to light and accommodation). Patient assisted back to the bed. (RP) notified. (PA) notified via message. DON (Director of Nursing) notified." Review of facility records and hospital records revealed Resident # 2 was transferred to the hospital for evaluation and admitted to the hospital on 1/16/23 for medical reasons which were not related to the fall. At admission a head CT was done which revealed no acute posttraumatic intracranial abnormality. X-rays of Resident # 2 ' s pelvis and foot were done and revealed no acute fractures. The admitting hospitalist noted Resident # 2 had experienced a fall but had no complaints and denied any pain related to the fall. NA # 1 had been the NA who was caring for Resident # 2 at the time of the fall on 1/15/23. NA # 1 was interviewed on 1/27/23 at 12:20 PM and reported the following. Resident # 2 was total care. He could move his arms some but could not move his legs. His legs were contracted. He had been providing Resident # 2 with incontinent care on the night of the incident. He had turned Resident # 2 onto his left side while providing the care. Resident # 2 was "half way in the middle and half way on the end" of the bed. He (NA # 1) was caring for Resident # 2 by himself and routinely did so without problems. He felt he had Resident # 2 in a safe position in the bed before the incident. Resident # 2 was a large resident and his bed was a regular bed. After removing Resident #2 ' s soiled brief, he (NA # 1) turned his back to the resident to discard the brief in the trashcan. The trashcan was near the middle of the room. He heard Resident # 2 say he was	F 689		

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F 689	Continued From page 6 slipping but did not see how he actually fell from the bed. NA # 2 was interviewed on 1/27/23 at 1:30 PM. NA # 2 reported the following in the interview. She had been caring for Resident # 2 ' s roommate at the time of the incident and was in the room. The curtain was pulled at the time of the incident and she could not see how he fell. While caring for the roommate, she heard Resident # 2 say he was slipping. She then went to Resident #2 ' s side of the room and noted him on the floor on his back. Nurse # 1 was interviewed on 1/27/23 at 2:50 PM and reported the following. She was alerted Resident # 2 had fallen. When she entered the room, she found Resident # 2 on the floor lying on his back. She asked what had happened and the NA reported he had been discarding an item in the trash when Resident # 2 reported he was slipping from the bed. She assessed Resident # 2 and he had no major physical injuries. He had a spot on his back which appeared as if it was a bruised area and old. He had a small bruised area on his right leg which was minor. Resident # 2 reported he was not in pain. He did not want to go to the hospital. She began every fifteen-minute neuro checks and at each check he reported no pain. Shortly after the incident, Resident # 2 ' s RP arrived and wanted him transferred to the hospital. Therefore, he was sent out for evaluation. On 1/28/2023 at 10:08 AM and 10:30 AM the Director of Nursing was interviewed about the incident. The Director of Nursing acknowledged Nurse Aide # 1 should not have turned his back on Resident # 2 during care. The Director of	F 689		

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F 689	Continued From page 7 Nursing stated in-services for all the nursing staff on turning and repositioning and not turning your back on a resident were initiated on 1/27/23 but the inservices had not yet been completed. The DON also indicated the size of the bed and the size of the resident might have contributed to the incident.	F 689		