STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 03/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(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 An unannounced complaint investigation survey was conducted from 3/6/2023 through 3/7/2023. Event ID#GJ2P11. The following intakes were investigated NC00195660, NC00197199, NC00198623. 2 of the 8 complaint allegations resulted in deficiency.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide treatment and dressing changes for a skin tear for 1 of 3 residents reviewed for wounds (Resident #1). The findings included: Resident #1 was admitted to the facility on 10/29/22 with cumulative diagnoses of Alzheimer's dementia and acute respiratory failure with hypoxia and pneumonia. Resident #1's admission Minimum Data Set (MDS) dated 11/4/22 indicated Resident #1 was severely cognitively impaired and required extensive assistance with all aspects of daily living, except eating. MDS did not indicate any	F 684	1. Resident #1 was discharged prior to the complaint survey; there were no changes to Resident #1□s chart. An audit was conducted on 3/14/2023 to ensure all residents receiving wound treatments had current & accurate orders. Any issues that were noted in relation to F684 were immediately corrected. The nurse who identified Patient #1's wound was educated on the policies and procedures on 3/8/23. The policies included: House Standing Orders (Skin Tears); Change in a Resident's Condition or Status; Acute Condition Changes-Clinical Protocol; and Residents□ Rights.	3/30/23

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

Electronically Signed | 03/27/2023

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F 684	Continued From page 1 pressure ulcer/injury. Review of wound assessment note dated 11/21/22 documented by Nurse #1, indicated a new, open, acute wound to Resident #1's sacrum/buttocks. The wound was 0.5cm (centimeter) x 0.5cm with no redness or exudate observed. No undermining or tunneling. Surrounding skin was clear. Periwound temperature was consistent with surrounding skin. No pain with dressing application. This is a new wound. Additions added to treatment, see physicians order. Incontinent of bladder, continent of bowel. An interview with Nurse #1 on 3/7/23 at 11:20am indicated she discovered the skin tear on Resident #1's right buttock on 11/21/22, cleaned it and applied a foam dressing per facility skin tear wound protocol and recorded it on the wound assessment document. She further explained the facilities process of entering the new wound into the electronic medical record to notify the wound nurse of any new treatments and notify the physician of new standing orders to be signed. She then indicated that she clearly had not remembered to implement these standing orders or to inform the next shift of her findings. Review of the 11/1/22 through 11/30/22 Physician orders showed no standing order initiated for wound care to Resident #1's sacrum/buttocks. Record review of 11/1/22 through 11/30/22 Medication Administration Record (MAR), and Treatment Administration Record (TAR) revealed no treatment orders for wound care to Resident #1's sacrum/buttocks.	F 684	2. A 100% skin check audit was completed by licensed nursing staff on 3/14/2023 to ensure there were no further skin tear issues identified. The residents charts were also audited to ensure that all identified wounds had appropriate orders. 3. On 03/29/2023, 100% of licensed nurses will be educated on the House Standing Orders (skin tears) Policy. Those who have not completed the education on 3/30/2023 will be removed from the schedule. New hires & agency staff will be trained on the House Standing Orders (skin tears) Policy prior to being allowed to work. 4. Beginning on 3/29/2023, the Administrator or DON or Designee will be responsible for auding the Risk Management report and Assessment Report weekly for 12 weeks. 5. The QAPI team, consisting of the Administrator, DON, ADON, Staff Development Coordinator, Wound Nurse, MDS nurses, Medical Records & other applicable parties met to discuss deficient practice on 3.8.23. The QAPI team will begin to meet weekly on 03/30/2023 to discuss audit and findings for compliance for this plan of correction. The Administrator will be responsible for bringing relevant findings regarding F684 to the QAPI Meeting.	

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F 684	Continued From page 2 Interview with facility Wound Nurse on 3/6/23 at 4:38pm indicated he did not recall Resident #1. Referencing his wound report documentation, he reported that Resident #1 did not have any wound care orders. He reported the standing order for a skin tear wound was a generic cleaner and a foam dressing, cleaned and dressing changed daily. He explained the process of their program, when the wound had been entered into their program, it added the standing orders for skin tear treatment to the TAR and alerts the MD to any new standing orders to be signed. He reported he would then print the daily wound report and any new wounds requiring treatments would be added. Review of wound assessment dated 11/30/22 documented by Nurse #1 revealed, skin tear to right buttock, category II, acquired in house on 11/21/22. Area: 18.5 cm (squared); L (length) 4.7 cm; W (width) 5.6 cm; 80% wound covered with epithelial, no evidence of infection; light drainage sanguineous/bloody, no odor; edges non-attached, edge appears as a cliff with surrounding tissue erythema/fragile, no warmth to surrounding skin; Dressing appearance is intact/saturated, cleansed with generic wound cleaner & foam dressing applied. Interview with Nurse #1 on 3/7/23 at 11:20am also revealed she had been assigned to Resident #1 on 11/30/22 but did not recall being asked anything concerning his wound or dressing needs from the family. However, she did assess his wound on 11/30/22, documented it as skin tear, measured it, cleaned it and applied a new foam dressing. Interview with the Director of Nursing (DON) on	F 684	6. Date of Compliance: 03/30/2023	

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F 684	Continued From page 3 3/7/23 at 1:45pm, revealed she was unaware of Resident #1 having an acute wound to his buttock and further revealed that she expected the standing order to have been written and transcribed to the TAR to ensure ongoing care from other shifts, and the wound nurse to have been notified for wound care follow up.	F 684		