STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053004	A. BUILDING: _____ B. WING _____	07/29/2016

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PARKVIEW RETIREMENT CENTER	1801 WICKER STREET EXT SANFORD, NC 27330

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on July 27- 29, 2016.	D 000		
D 163	10A NCAC 13F .0504(c) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (c) Competency validation of staff, according to Paragraph (a) of this Rule, for the licensed health professional support tasks specified in Paragraph (a) of Rule .0903 of this Subchapter and the performance of these tasks is limited exclusively to these tasks except in those cases in which a physician acting under the authority of G.S. 131D-2(a1) certifies that non-licensed personnel can be competency validated to perform other tasks on a temporary basis to meet the resident's needs and prevent unnecessary relocation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure non-licensed staff were competency validated to apply debriding agents (Medihoney and Santyl) to a pressure ulcer for 1 resident (Resident #5) and prior to performing wound care and packing of wounds for 1 resident (Resident #4) with Stage IV pressure ulcers. The findings are: A. Review of Resident #5's current FL-2 dated 07/07/16 revealed: -Diagnoses included gross hematuria, deep-vein thrombosis right lower extremity, and	D 163		

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gastrointestinal blood loss with anemia.
-A check mark beside "decubiti" with no further information regarding the decubitus.
-A physician's order for Santyl (enzymatic debriding agent) topically to wound and Medihoney (autolytic debriding agent).

Review of Resident #5's record revealed:
-A verbal order from the physician dated 06/11/16: "Right hip pressure area - call wound clinic (designated clinic) on Monday 06/13/16".
-Resident #4 was evaluated at the wound care clinic on 06/20/16 at 1:00 pm for a "right hip pressure wound".
-A physician's order dated 06/20/16 for Medihoney HCL patch dressing or Medihoney gel. Cover with adaptive 4x4 gauze dressing.
-A staff communication to the physician dated 06/26/16: "Pt. has taken Medihoney dressing off his right hip wound daily. Dressing has to be changed several times a day".
-A physician's order dated 06/27/16: "New wound orders. Daily Santyl ointment, Hydrafera Blue dressing".

Observation on 07/28/16 at 10:11am of Resident #5's wound care revealed:
-Staff A removed a blue, foam dressing from the resident's right hip revealing a Stage II (superficial ulcer involving the epidermis or dermis or both) pressure ulcer measuring approximately 2.5x0.5 cm.
-The wound was clean and had new, pink skin covering the area. There was no drainage or odor. There was superficial reddening of the skin surrounding the wound which ranged from an approximate width of 1 to 3 cm.
-Staff A cleaned the wound with normal saline, cut a 1.5x3 inch blue foam dressing from a larger piece, applied a 1.5-cm ribbon of Santyl to the

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blue dressing, placed the dressing on the wound, and secured it with paper tape.

Review of Resident #5's June 2016 Medication Administration Record (MAR) revealed:
-An entry dated 06/20/16 to wash right hip area with soap and water, then apply Medihoney and cover with a 4x4 dressing.
-The Medihoney dressing was documented as applied daily from 06/20/16 through 06/26/16 by facility medication aides (MAs).
-On 06/27/16, a new entry for daily Santyl ointment to right hip wound and cover with Hydrofera Blue foam dressing.
-The Santyl was documented as applied daily from 06/27/16 through 06/29/16 by facility MAs; the entry was blank on 06/30/16.

Review of Resident #5's July 2016 MAR revealed:
-An entry for Hydrofera Blue foam dressing over Santyl daily to right hip wound.
-The Santyl and Hydrofera Blue dressing was documented as applied daily from 07/01/16 through 07/28/16 by facility MAs.

Review of Staff C's personnel record revealed:
-A hire date of 11/09/99 as a nursing assistant with a later transition to medication aide (unknown date).
-Documentation of successful completion of the written medication aide test on 04/30/01.
-LHPS Validations dated 05/27/02 and annually through 01/01/16.
-Staff A was validated to perform "clean dressing changes, excluding packing wounds" and "care for pressure ulcers up to and including Stage II pressure ulcers" on the LHPS Validations.
-There was no documentation of physician certification or LHPS Validations to apply Medihoney or Santyl.

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D 163	Continued From page 3 Staff C was unavailable for interview on 07/28/16. Review of Staff A's personnel record revealed: -A hire date of 03/11/13 as a nursing assistant with a later transition to medication aide (unknown date). -Documentation of successful completion of the written medication aide test on 05/20/14. -LHPS (Licensed Health Professional Support) Validations dated 03/15/13, 01/03/15, and 01/01/16. -Staff A was validated to perform "clean dressing changes, excluding packing wounds" on the three LHPS Validation forms. -Staff A was validated to perform "care for pressure ulcers up to and including Stage II pressure ulcers" on the LHPS Validations dated 01/03/15 and 01/01/16. -There was no documentation of physician certification or LHPS Validations to apply Medihoney or Santyl. Interview on 07/28/16 at 10:27 am with Staff A revealed: -She had been a medication aide for "over a year" and was the Supervisor on day shift. -Resident #5 was admitted to the facility in May 2016 and had some redness of his right hip, but there was no open wound. -The staff were not putting anything on the resident's hip at that time. -The resident went out to the hospital for one day for an unrelated medical issue in July 2016 and returned to the facility with an order for a referral to the wound clinic. -The physician at the wound clinic initially ordered Medihoney, which was later changed to Santyl about 3 weeks ago. -Staff A routinely worked 5 days a week and	D 163		

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completed the wound care when she was working.
-Another MA, usually Staff C, completed the wound care when Staff A was not on duty.
-She was not aware of any limitations on the type of wound care or treatment agents she could apply, but was able to do "whatever the doctor orders".
-"I haven't had anything come in that I wasn't able to do".
-If a physician ordered a treatment staff could not do, the Co-Administrator (a Registered Nurse) or the facility LPN (Licensed Practical Nurse) would step in, "but there have been no cases of that".
-Staff A was not aware routine LHPS validation excluded application of debriding agents or that Medihoney and Santyl were debriding agents.

Interview on 07/28/16 at 10:47 am with the facility LPN revealed:
-She had worked at the facility for 47 years.
-She did most of the training for new medication aides, which included training for dressing changes.
-She was not aware of any wound treatment agents the MAs could not apply.
-She was not aware routine LHPS validation of MAs excluded the application of debriding agents and stated as long as there was a doctor's order, staff could do whatever treatment was ordered.
-She was not aware MAs could not apply debriding agents without a physician certification and specific LHPS competency validation.

Interview on 07/28/16 at 11:02 am with the Co-Administrator revealed:
-She was a Registered Nurse (RN).
-She and the LPN provided training for new MAs, but she completed the LHPS Validations because she was the RN.

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-There were no limitations on the type of wound care or treatment agents the MAs could provide as long as "hospice or somebody" was following them.
-She was not aware Santyl was being used by the MAs or that Santyl was a debriding agent.
-She was not aware MAs could not apply wound debriding agents without a physician certification and specific LHPS competency validation.

Interview on 07/29/16 at 9:22 am with a nurse from the wound clinic revealed:
-She did not know wound debriding agents were outside the scope of routine care MAs were allowed to provide.
-The debriding agent was ordered to break down the fibrin, so she did not know what alternative might have been used if the physician had been aware.

B. Review of Resident #4's current FL-2 dated 03/23/16 revealed:
-Diagnoses included Alzheimer's disease, deep vein thrombosis, and anemia.
-Decubiti on coccyx and left hip.
-A physician's order for Flagyl (antifungal) 500 mg, crush 1-1/2 tablets and apply to hip and coccyx wound twice daily and as needed if soiled. Cover with wet-to-dry normal saline dressing.

Review of Resident #4's physician orders revealed:
-A hospice recertification dated 06/16/16 for skilled nursing once weekly.
-A physician's order dated 06/27/16 to clean left hip and coccyx with normal saline. Apply crushed Flagyl to both wounds. Apply wet to dry dressing twice daily and as needed if soiled by "FS/SN" (facility staff/skilled nurse).
-A physician's order dated 07/06/16 to change

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coccyx and left hip dressing to: Clean with normal saline. Apply wet to dry dressing every day and as needed if soiled.
-A physician's order dated 07/28/16 for hospice nurse to do daily dressing changes on "Stage IV left hip and Stage IV coccyx wounds". Clean both wounds with normal saline. Apply wet to dry dressing securing with paper tape. To be done daily and as needed if dressing is soiled. Facility staff to call hospice nurse if dressing is soiled and needs to be changed.

Observation on 07/27/16 at 2:39 pm of the resident's wound care performed by Staff A, Medication Aide, revealed:
-Staff A removed a 4x6 outer dressing from the resident's left hip to reveal a large wound with gauze packing.
-Staff A removed the gauze packing to reveal a Stage IV (extending into muscle or bone) pressure ulcer measuring approximately 7.5x5 cm with a depth of approximately 2 mm.
-The gauze packing had yellow/brown drainage and a strong, foul odor.
-The wound bed was clean with pink/red tissue. There was superficial reddening of the skin surrounding the wound which ranged from an approximate width of 1.5 cm to 2.5 cm.
-Staff A soaked a 4x4 gauze dressing with normal saline, unraveled the gauze and packed it inside the wound, poured additional normal saline over the packing and used a dry gauze dressing to dry the skin around the wound.
-Staff A placed a 4x6 nonstick dressing over the packed wound and secured it with paper tape.
-Staff A removed a 4x6 outer dressing from the resident's coccyx to reveal a large wound with gauze packing.
-Staff A removed the gauze packing to reveal a Stage IV round pressure ulcer measuring

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approximately 7 cm in diameter with an approximate depth of 4 mm.
-The gauze packing had green/brown/yellow drainage and a faint foul odor.
-The wound bed was clean and was comprised half of pink/red tissue and the other half shiny and white, and appeared to be bone. There was a 3-cm border of superficial reddening of the skin surrounding the wound.
-Staff A performed the same procedure of left wound packing and covering as described above with the hip wound.

Observation on 07/28/16 at 9:45 am of Resident #4's wound care revealed:
-Staff A performed wound care to the Stage IV pressure ulcers on the left hip and the coccyx using the same procedure observed on 07/27/16.
-The gauze packing removed from the left hip wound had light brown drainage and no noted odor.
-The gauze packing removed from the coccyx wound had dark brown/yellow drainage and no noted odor.

Review of Resident #4's July 2016 Medication Administration Record (MAR) revealed:
-From 07/01/16 through 07/06/16, the MAR included instructions to crush Flagyl 500 mg, one and one-half tablets and apply to the left hip and coccyx wound twice daily and as needed if soiled, cover with normal saline wet to dry dressing.
-The above wound order was documented as completed by facility medication aides twice daily from 07/01/16 through 07/06/16.
-The above wound order was discontinued on 07/06/16 with a new entry to clean coccyx and left hip wounds with normal saline, apply wet to dry dressing every day and as needed if soiled.
-The wet to dry dressings were documented as

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completed by facility medication aides daily from 07/07/16 through 07/28/16 (22 occasions).
-Staff A and Staff C, Medication Aides, documented completion of wound care for 20 of the 22 occasions from 07/07/16 through 07/28/16.

Review of Staff C's personnel record revealed:
-A hire date of 11/09/99 as a nursing assistant with a later transition to medication aide (unknown date).
-Documentation of successful completion of the written medication aide test on 04/30/01.
-LHPS Validations dated 05/27/02 and annually through 01/01/16.
-Staff A was validated to perform "clean dressing changes, excluding packing wounds" and "care for pressure ulcers up to and including Stage II pressure ulcers" on the LHPS Validations.
-There was no documentation of physician certification or LHPS Validations to perform wound packing or care of Stage IV pressure ulcers.

Staff C was unavailable for interview on 07/28/16.

Review of Staff A's personnel record revealed:
-A hire date of 03/11/13 as a nursing assistant with a later transition to medication aide (unknown date).
-Documentation of successful completion of the written medication aide test on 05/20/14.
-LHPS (Licensed Health Professional Support) Validations dated 03/15/13, 01/03/15, and 01/01/16.
-Staff A was validated to perform "clean dressing changes, excluding packing wounds" on the three LHPS Validation forms.
-Staff A was validated to perform "care for pressure ulcers up to and including Stage II

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pressure ulcers" on the LHPS Validations dated 01/03/15 and 01/01/16.
-There was no documentation of physician certification or LHPS Validations to perform wound packing or care of Stage IV pressure ulcers.

Interview on 07/28/16 at 10:27 am with Staff A revealed:
-She had been a medication aide for "over a year" and was the Supervisor on day shift.
-Resident #4's hip and coccyx wounds had been present before she became a medication aide (MA).
-She routinely worked 5 days a week and completed the wound care when she was working.
-Another MA, usually Staff C, completed the wound care when Staff A was not on duty.
-She was not aware of any limitations on the type or extent of wound care she could provide, but was able to do "whatever the doctor orders".
-"I haven't had anything come in that I wasn't able to do".
-If a physician ordered a treatment staff could not do, the Co-Administrator (a Registered Nurse) or the facility LPN (Licensed Practical Nurse) would step in, "but there have been no cases of that".
-Staff A was not aware routine LHPS validation excluded packing of wounds and care for pressure ulcers greater than Stage II.

Interview on 07/28/16 at 10:47 am with the facility LPN revealed:
-She had worked at the facility for 47 years.
-She did most of the training for new medication aides, which included training for dressing changes.
-She was not aware of any limitations on the type or extent of wound care MAs could provide.

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D 163	Continued From page 10 -She was not aware routine LHPS validation of MAs excluded packing of wounds and care for pressure ulcers greater than Stage II, and stated as long as there was a doctor's order, staff could do whatever treatment was ordered. -She was not aware MAs could not pack wounds or care for pressure ulcers greater than Stage II without a physician certification and specific LHPS competency validation. Interview on 07/28/16 at 11:02 am with the Co-Administrator revealed: -She was a Registered Nurse (RN). -She and the LPN provided training for new MAs, but she completed the LHPS Validations because she was the RN. -There were no limitations on the type or extent of wound care the MAs could provide as long as "hospice or somebody" was following them. -She was not aware MAs could not pack wounds or care for pressure ulcers greater than Stage II without a physician certification and specific LHPS competency validation. Interview on 07/28/16 at 8:52 am with the Director of Operations for a local hospice organization revealed: -Resident #4 had several Start-Of-Care (SOC) dates, the most recent being 08/31/15. -A skilled nurse visited the resident an average of once weekly and was supposed to do the resident's wound care weekly, but sometimes the nurse documented the wound care had already been done by staff and she would not observe the wounds, but would ask for a report of what the wounds looked like from facility staff. -She was not aware of any limitations on the type or extent of wound care the MAs could provide. -If the facility had notified hospice they were unable to manage a particular wound, the	D 163		

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D 163	Continued From page 11 hospice nurse would come to the facility every day to perform the wound care. Interview on 07/28/16 at 9:57 am with a hospice nurse revealed: -She saw Resident #4 this week on 07/25/16 because the regular nurse was on vacation, but she used to be the resident's regular nurse. -Resident #4's wounds were chronic; the hip wound had been present for close to 4 years and she was unsure how long the coccyx wound had been present, but it was also chronic. -She performed measurements on the resident's wounds on 07/25/16, both of which are currently Stage IV wounds. -The nurse confirmed the white matter comprising half of the coccyx wound was bone. -She was not aware of any limitations on the type or extent of wound care the MAs could provide. -If a facility notified hospice they could not provide care for a wound due to severity, the hospice staff would perform the treatment until other arrangements could be made or until the resident could be transferred to a skilled facility. -The nurse was not aware of the limitations of care that could be provided by MAs and would rely on the facility to inform her if physician orders were beyond the MAs scope of practice. Based on observations, record reviews and interviews with staff, it was determined Resident #4 was not interviewable. On 07/29/16, the Co-Administrator submitted a Plan of Protection as follows: -Facility will no longer allow staff to do any dressings on residents that require Stage III or IV pressure ulcer dressings. -Facility contacted hospice to do daily dressings. -Also will no longer use debriding agents unless	D 163		

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D 163	Continued From page 12 by RN/LPN. -An inservice will be done today for all MAs. -Will put this as a quality assurance monthly program. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 12, 2016.	D 163		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.	D 280		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure the quarterly Licensed Health Professional Support (LHPS) evaluations were completed within 30 days from the date a resident developed the need for the task and included a physical assessment, evaluation of the resident's progress to care, and recommendations for changes in care for 4 of 5 sampled residents (Residents #1, #3, #4, and #5) with LHPS tasks of caring for transferring, physical therapy and occupational therapy, pressure ulcers, and physical restraints.

The findings are:

A. Review of Resident #5's current FL-2 dated 07/07/16 revealed:
-Diagnoses included gross hematuria, deep-vein thrombosis right lower extremity, and gastrointestinal blood loss with anemia.
-A check mark beside "decubiti" with no further information regarding the decubitus.
-A physician's order for Santyl (enzymatic debriding agent) topically to wound and Medihoney (autolytic debriding agent).

Review of the Resident Register revealed Resident #5 was admitted to the facility on 05/18/16.

Review of Resident #5's care plan revealed:
-The initial care plan was completed on 05/18/16 with a notation under Other: "Has reddened area right hip bone".
-An addition to the care plan dated 06/11/16 with a notation under Other: "Right hip ulcer (to go to wound clinic) June 20th".
-A second addition to the care plan dated 06/20/16 with a notation under Other: "Right hip

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D 280	Continued From page 14 ulcer-dx ([Named Resident] takes dx off)". Review of Resident #5's LHPS evaluation dated 05/18/16 revealed: -There was no identification or assessment of the right hip wound on the 05/18/16 evaluation. -There were no further LHPS evaluations completed for Resident #5. Review of Resident #5's record revealed: -A verbal order from the physician dated 06/11/16: "Right hip pressure area - call wound clinic (designated clinic) on Monday 06/13/16". -Resident #4 was evaluated in the wound care clinic on 06/20/16 at 1:00 pm for a "right hip pressure wound". -A physician's order dated 06/20/16 for Medihoney HCL patch dressing or Medihoney gel. Cover with adaptive 4x4 gauze dressing. -A staff communication to the physician dated 06/26/16: "Pt. has taken Medihoney dressing off his right hip wound daily. Dressing has to be changed several times a day". -A physician's order dated 06/27/16: "New wound orders. Daily Santyl ointment, Hydrafera Blue dressing". Observation on 07/28/16 at 10:11 am of Resident #5's wound care revealed: -Staff A removed a blue, foam dressing from the resident's right hip revealing a Stage II (superficial ulcer involving the epidermis or dermis or both) pressure ulcer measuring approximately 2.5x0.5 cm. -The wound was clean and had new, pink skin covering the area. There was no drainage or odor. There was superficial reddening of the skin surrounding the wound which ranged from an approximate width of 1 to 3 cm. -Staff A applied a 1.5-cm ribbon of Santyl on the	D 280		

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blue dressing, placed the Santyl and dressing on the wound, and covered the dressing with paper tape.

Interview on 07/28/16 at 11:02 am with the Co-Administrator revealed:
-She was a Registered Nurse.
-She was responsible for completing the quarterly LHPS evaluations for residents with LHPS tasks.
-She did not know Santyl was being used for Resident #4 or that Santyl was a debriding agent.

Refer to interview on 7/29/16 at 12:00 pm with a Co-Administrator.

Refer to interview on 7/29/16 at 12:30 pm with the Resident Care Coordinator.

B. Review of Resident #4's current FL-2 dated 03/23/16 revealed:
-Diagnoses included Alzheimer's disease, deep vein thrombosis, and anemia.
-Decubiti on coccyx and left hip.
-A physician's order for Flagyl (antifungal) 500 mg, crush 1-1/2 tablets and apply to hip and coccyx wound twice daily and as needed if soiled. Cover with wet-to-dry normal saline.

Review of Resident #4's physician orders revealed:
-A hospice recertification dated 06/16/16 for skilled nursing once weekly.
-A physician's order dated 06/27/16 to clean left hip and coccyx with normal saline. Apply crushed Flagyl to both wounds. Apply wet to dry dressing twice daily and as needed if soiled by "FS/SN" (facility staff/skilled nurse).
-A physician's order dated 07/06/16 to change coccyx and left hip dressing to: Clean with normal saline. Apply wet to dry dressing every day and

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D 280	Continued From page 16 as needed if soiled. -A physician's order dated 07/28/16 for hospice nurse to do daily dressing changes on "Stage IV left hip and Stage IV coccyx wounds". Clean both wounds with normal saline. Apply wet to dry dressing securing with paper tape. To be done daily and as needed if dressing is soiled. Facility staff to call hospice nurse if dressing is soiled and needs to be changed. Observation on 07/27/16 at 2:39 pm of the resident's wound care performed by Staff A, Medication Aide, revealed: -Staff A removed a 4x6 outer dressing from the resident's left hip to reveal a large wound with gauze packing. -Staff A removed the gauze packing to reveal a Stage IV (extending into muscle or bone) pressure ulcer measuring approximately 7.5x5 cm with a depth of approximately 2 mm. -The gauze packing had yellow/brown drainage and a strong, foul odor. -The wound bed was clean with pink/red tissue. There was superficial reddening of the skin surrounding the wound which ranged from an approximate width of 1.5 cm to 2.5 cm. -Staff A removed a 4x6 outer dressing from the resident's coccyx to reveal a large wound with gauze packing. -Staff A removed the gauze packing to reveal a Stage IV round pressure ulcer measuring approximately 7 cm in diameter with an approximate depth of 4 mm. -The gauze packing had green/brown/yellow drainage and a faint foul odor. -The wound bed was clean and was comprised half of pink/red tissue and the other half shiny and white, and appeared to be bone. There was a 3-cm border of superficial reddening of the skin surrounding the wound.	D 280		

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D 280	Continued From page 17 Review of Resident #4's record revealed: -An LHPS evaluation dated 12/25/15 with the following notation regarding wounds: "Wound is clean and healing." There was no further information regarding the resident's wounds. -The 12/25/15 evaluation did not include an assessment of the wounds, location or size of wounds, drainage or odor, the resident's response to the care being provided, or recommendations for changes to the care being provided. -An LHPS evaluation dated 03/25/16 with the following notation regarding wounds: "Wounds are clean - wet to dry dressing (Flagyl put on also)". There was no further information regarding the resident's wounds. -The 03/25/16 LHPS evaluation did not include an assessment of the wounds, location or size of wounds, drainage or odor, the resident's response to the current care being provided, or recommendations for changes to the care being provided. -An LHPS evaluation dated 05/04/16 identified "ulcer care" as an LHPS task, but there was no information regarding the resident's wounds, location or size, drainage or odor, the resident's response to the current care provided, or recommendations for changes to the care being provided. Interview on 07/28/16 at 11:02 am with the Co-Administrator revealed: -She was a Registered Nurse. -She was responsible for completing the quarterly LHPS evaluations for residents with LHPS tasks. -She performed complete assessments of Resident #4: "My assessment was that she had wounds". -The hospice nurse performed a more complete	D 280		

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assessment of Resident #4's wounds on a weekly basis.

Interview on 07/28/16 at 8:52 am with the Director of Operations for a local hospice organization revealed:
-Resident #4 had several Start-Of-Care (SOC) dates, the most recent being 08/31/15.
-A skilled nurse visited the resident an average of once weekly and was supposed to do the Resident #4's wound care weekly, but sometimes the nurse documented the wound care had already been done and she had discussed the appearance of the residents wounds with the facility staff.

Review of hospice skilled nurse notes revealed:
-Resident #4 had 33 hospice skilled nurse visits from 12/09/15 through 07/25/16.
-Of the 33 skilled nurse visits, 27 documented the wounds were not assessed by the skilled nurse, but "by facility staff" and that wound care was provided by the facility staff.
-Skilled nurse assessments and wound care of the resident's wounds was completed on 12/09/15, 04/11/16, 04/18/16, 05/23/16, 07/11/16, and 07/25/16.

Refer to interview on 7/29/16 at 12:00 pm with a Co-Administrator.

Refer to interview on 7/29/16 at 12:30 pm with the Resident Care Coordinator.

C. Review of Resident #3's current FL-2 dated 05/24/16 revealed:
-Diagnoses included dementia and chronic obstructive pulmonary disease.
-There was no documentation for ambulatory status.

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D 280	Continued From page 19 Review of the Resident Register revealed Resident #3 was admitted to the facility on 06/15/15. Observation, during the initial tour, on 07/27/16 at 11:00 am of Resident #3 revealed: -The resident was lying in bed. -One side of the bed was positioned against the wall and the other side had a full length bedrail in the up position. -The resident was laying flat in the bed, on his back. -The resident did not make any major positional changes or attempt to get out of the bed. Observations at various times on 07/28/16 and 07/29/16 revealed: -On 07/28 at 10:50 am, resident in recliner in room. -On 07/28 at 3:10 pm, resident in bed with bedrail up. -Continuous observation on 07/29 from 10:20 am to 10:45 am revealed the resident was asleep with bedrail up; at 10:45 am 2 staff lowered bedrail, changed checked resident for continence and moved resident to recliner. -Continuous observation on 07/29 from 10:55 am to 11:17 am revealed the resident was asleep in the recliner with no movement. Review of Resident #3's current Care Plan dated 04/22/16 revealed: -Resident #3 was assessed for totally dependent with assistance by staff for toileting, bathing, and dressing. -Resident #3 was assessed for extensive assistance by staff with transferring. -Resident #3 was assessed for limited assistance by staff with eating, ambulation, and grooming.	D 280		

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D 280	Continued From page 20 Review of the current Licensed Health Professional Support (LHPS) review dated 07/02/16 revealed: -The use of a physical restraint (bedrail) was not marked on the LHPS. -There was no assessment for the use of a restraint documented on the LHPS. -There was no assessment for staff assisting with transfers documented on the LHPS. Interview on 07/28/16 at 11:30 am and 12:20 pm with Resident #3 revealed: -He was feeling much better since coming to the facility. -He was not aware why the rails were on his bed. -He was not sure he could put the side rail down himself. (He was not sure how it released.) -Staff assisted him when he moved from the recliner to the bed, and from the bed or recliner to his wheelchair when he went to the dining area. Interview on 07/29/16 at 10:50 am with a first shift Personal Care Aide (PCA) revealed: -She routinely put Resident #3's bedrail up every time she assisted getting him in and out of bed. -Resident #3 needed assistance with transferring from the bed or the recliner. -She thought Resident #3 was at least a single person assist with transfers however, since she was small, she always asked another staff member to assist when she transferred Resident #3. Interview on 07/29/16 at 11:58 am with a Co-Administrator revealed: -She was a Registered Nurse. -She completed most of the LHPS Quarterly updates. -The Resident Care Coordinator (RCC)	D 280		

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occasionally assisted in completing the LHPS.
-The Supervisor, Medication Aides, and RCC helped her identify LHPS task for residents.
-She was not aware Resident #3 needed the bedrails, and assist with transferring added to the LHPS tasks on the LHPS Task Quarterly assessment.

Refer to interview on 7/29/16 at 12:00 pm with a Co-Administrator.

Refer to interview on 7/29/16 at 12:30 pm with the Resident Care Coordinator.

D. Review of Resident #1's current FL2 dated 5/18/16 revealed diagnoses included age related osteoporosis, spinal stenosis, localized edema, vitamin D deficiency, unsteadiness on feet, muscle weakness, Cardiac Pacemaker, Heart Cerebral Vascular Accident.

Review of Resident #1's Resident Register revealed an admission date of 10/20/14.

1. Further review of Resident #1's FL2 dated 5/18/16 revealed:
-Resident #1 was non-ambulatory.
-Resident #1 needed personal care assistance by staff with bathing, feeding and dressing.

Review of Resident #1's Licensed Health Professional Support (LHPS) Review and Evaluation dated 5/14/16 revealed:
-There were no LHPS tasks listed for transferring.
-Documentation of a physical assessment as related to diagnoses/current condition and progress to care provided of the resident was "Semi-ambulatory seated in wheel chair" and "Complains of back and leg pain".
-There was no documentation of a physical

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assessment as to the type of transfer, the number of staff required for transfer or resident tolerance and response to transfer.
-The LHPS review was signed by a Registered Nurse (Co-Administrator).

Review of Resident #1's Care Plan dated 5/14/16 revealed:
-Resident #1 had a non-ambulatory status.
-Resident #1 needed extensive assistance by staff with toileting, ambulation and locomotion, bathing, dressing and transferring.
-Resident #1 needed supervision with grooming and personal hygiene.
-There were no LHPS tasks listed on the Care Plan.
-The Care Plan was signed by a Registered Nurse and a physician.

Interview on 7/27/16 at 10:50 am with Resident #1 revealed:
-She had resided in the facility since 2014, but was recently in rehabilitation for a hip fracture and came back to the facility on 5/18/16.
-She had complete left sided paralysis.
-She required assistance from staff with transferring and locomotion, dressing, bathing, and toileting.
-She had recently sustained a left foot fracture when a family member had transferred her from the wheelchair onto the toilet and her ankle twisted and that was how she fractured her foot.
-Her bones were very brittle and break easily.
-She required 2 people to assist her with transfers.

Observation of Resident #1 on 7/27/16 at 10:55 am revealed:
-The resident was lying in the bed watching television.

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D 280	Continued From page 23 -There was a soft cast on the resident's left lower leg and foot. Interview on 7/28/16 at 10:32 am with a Personal Care Aide (PCA) revealed: -She provided assistance with personal care for Resident #1 which included dressing and bathing. -Resident #1 required 2 person assistance with transfers. -A Co-Administrator did the LHPS training annually for all staff. -Return demonstration was not typically a part of the annual training unless staff did not understand a task, then the Co-Administrator would observe staff perform the task. Interview on 7/28/16 at 10:58 am with a Medication Aide (MA) revealed: -Resident #1 was total care and was not ambulatory at this time because of her fractured left foot. -Resident #1 was a 2 person assist with transferring. -Her family member came daily to visit. Refer to interview on 7/29/16 at 12:00 pm with a Co-Administrator. Refer to interview on 7/29/16 at 12:30 pm with the Resident Care Coordinator. 2. Review of Resident #1's FL2 dated 5/18/16 revealed: -She needed personal care assistance by staff with bathing, feeding and dressing. -A physician's order for physical therapy (PT) and occupational therapy (OT). Review of Resident #1's Licensed Health Professional Support (LHPS) Review and	D 280		

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D 280	Continued From page 24 Evaluation dated 5/14/16 revealed: -There were no LHPS tasks listed for PT and OT provided. -There was no documentation of a physical assessment as to the type of therapy prescribed, frequency of therapy, therapy provided by PT or OT, and resident's response to therapy. -The LHPS review was signed by a Registered Nurse (Co-Administrator). Interview on 7/27/16 at 10:50 am with Resident #1 revealed: -She had resided in the facility since 2014, but was recently in rehabilitation for a foot fracture and came back to the facility on 5/18/16. -She was receiving PT twice a week since her admission to the facility on 5/18/16 up until last week. -She had complete left sided paralysis. -Her bones were very brittle and break easily. Observation on 7/27/16 at 10:55 am with Resident #1 revealed: -The resident was lying in the bed watching television. -There was a soft cast on the resident's left lower leg and foot. Interview on 7/28/16 at 10:32 am with a Personal Care Aide (PCA) revealed: -She provided assistance with personal care for Resident #1 which included dressing and bathing. -A Co-Administrator did the LHPS training annually for all staff. -Return demonstration was not typically a part of the annual training unless staff did not understand a task, then the Co-Administrator would observe staff perform the task. Interview on 7/28/16 at 10:58 am with a	D 280		

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D 280	Continued From page 25 Medication Aide (MA) revealed: -Resident #1 was total care and was not ambulatory at this time because of her fractured left foot. -PT had been working with the resident since she was admitted back to the facility in May 2016. -Her family member came daily to visit. Interview on 7/28/16 at 11:44 am with a Physical Therapist revealed: -Resident #1 had been receiving physical therapy since she came back to the facility on 5/18/16. -Resident #1 was discharged from physical therapy within the last two weeks, after meeting her goals. Interview on 7/29/16 at 11:35 am with Resident #1's family member revealed: -She was very pleased with the care provided by the staff at the facility. -She was the reason Resident #1 sustained a fracture of the left foot and felt "bad" about it. -She did not ask staff for assistance with transfers when she was visiting because the therapist at the rehabilitation center had recommended 1 person assist due to a second person could sometimes be an obstacle. -Resident #1 had been receiving PT twice a week since her admission to the facility on 5/18/16 until last week when PT was discontinued because the resident had met her goals. Refer to interview on 7/29/16 at 12:00 pm with a Co-Administrator. Refer to interview on 7/29/16 at 12:30 pm with the Resident Care Coordinator. Interview on 7/29/16 at 12:00 pm with a Co-Administrator revealed:	D 280		

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D 280	Continued From page 26 -She was responsible for the LHPS review. -She was a Registered Nurse. -She maintained an LHPS log and when an LHPS review was due to be done, the Resident Care Coordinator (RCC) would flag the LHPS in the log book. -The RCC would accompany the Co-Administrator to the residents' rooms when she completed the LHPS assessments. -She kept in constant contact with the RCC to ensure the LHPS reviews were completed timely. The RCC also kept in contact with her "by word of mouth" when new LHPS tasks were ordered on the residents. -She completed the LHPS reviews on a continuous basis. -She was not aware there were some LHPS tasks and assessments that had not been addressed on the residents' current LHPS reviews. Interview on 7/29/16 at 12:30 pm with the RCC revealed: -She kept the Co-Administrator informed "by word of mouth" of the tasks to be addressed on the residents' LHPS for assessments. -She did accompany the Co-Administrator to the residents' rooms when the Co-Administrator conducted the assessments for the residents' listed tasks. -The Co-Administrator was responsible for keeping up with when the LHPS reviews were due by flagging them from the last LHPS review in the LHPS log book.	D 280		
D 484	10A NCAC 13F .1501(c) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501 Use Of Physical Restraints And ALternatives	D 484		

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D 484	Continued From page 27 (c) In addition to the requirements in Rules 13F .0801, .0802 and .0903 of this Subchapter regarding assessments and care planning, the resident assessment and care planning prior to application of restraints as required in Subparagraph (a)(5) of this Rule shall meet the following requirements: (1) The assessment and care planning shall be implemented through a team process with the team consisting of at least a staff supervisor or personal care aide, a registered nurse, the resident and the resident's responsible person or legal representative. If the resident or resident's responsible person or legal representative is unable to participate, there shall be documentation in the resident's record that they were notified and declined the invitation or were unable to attend. (2) The assessment shall include consideration of the following: (A) medical symptoms that warrant the use of a restraint; (B) how the medical symptoms affect the resident; (C) when the medical symptoms were first observed; (D) how often the symptoms occur; (E) alternatives that have been provided and the resident's response; and (F) the least restrictive type of physical restraint that would provide safety. (3) The care plan shall include the following: (A) alternatives and how the alternatives will be used prior to restraint use and in an effort to reduce restraint time once the resident is restrained; (B) the type of restraint to be used; and (C) care to be provided to the resident during the time the resident is restrained.	D 484		

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D 484	Continued From page 28	D 484		

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure documentation of an assessment and care planning through a team process and attempted alternatives prior to the use of restraints for 1 of 3 sampled residents (Residents #3) with bedrails.

The findings are:

Review of Resident #3's current FL-2 dated 05/24/16 revealed:
-Diagnoses included dementia and chronic obstructive pulmonary disease.
-There was no documentation for ambulatory status.

Review of the Resident Register revealed Resident #3 was admitted to the facility on 06/15/15.

Observation, during the initial tour, on 07/27/16 at 11:00 am of Resident #3 revealed:
-The resident was lying in bed.
-One side of the bed was positioned against the wall and the other side had a full length bedrail in the up position.
-The resident was laying flat in the bed, on his back.
-The resident did not make any major positional changes or attempt to get out of the bed.

Observations at various times on 07/28/16 and 07/29/16 revealed:
-On 07/28 at 10:50 am, resident in recliner in room.
-On 07/28 at 3:10 pm, resident in bed with bedrail

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D 484	Continued From page 29 up. -Continuous observation on 07/29 from 10:20 am to 10:45 am- resident asleep with bedrail up; at 10:45 am 2 staff lowered rail, changed checked resident for continence and moved resident to recliner; from 10:55 am to 11:17 am- resident was asleep in the recliner with no movement. Review of Resident #3's record revealed: -No current physician's order for full bedrails. -Documentation the resident's Power of Attorney/Family Member had signed a consent, for the use of a short or long bedrail as an enabler for the resident to turn themselves in bed or to move up in the bed, and understanding that using a long or short bedrail could be considered a restraint, on 06/30/15. Review of Resident #3's record revealed: -No updated Care Plan documenting alternatives provided before using the restraint, the type of restraint to be used; and care to be provided to the resident during the time the resident is restrained. (Current Care Plan was dated 04/22/16.) -No medical need to warrant the use of the restraint. -No documentation when the medical symptoms were first observed. -No documentation how often the symptoms occur. -No documentation that alternatives had been provided and the resident's response. -No documentation of the least restrictive type of physical restraint that would provide safety. -No documentation for how often the restraint should be released. -No documentation Resident #3's Power of Attorney/Family Member was invited to participate in discussion of using a restraint.	D 484		

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D 484	Continued From page 30 Review of Resident #3's record revealed the facility had a "PHYSICAL RESTRAINT ELIMINATION ASSESSMENT" for Resident #3 with information as follows: -Assessment dates of 04/21/16, and 07/02/16. -Physical functioning assessments for ambulation, transfer, bed mobility (uses to turn side to side), sitting balance, one person assist with bathing, dressing and grooming, history of falls, and visual status. -Behavioral/social functioning assessments for orientation (disoriented), comprehension, mood, activity participation, and medication therapy. -The resident was assessed for request long siderails as enabler for positioning. Review of Resident #3's current Care Plan dated 04/22/16 revealed: -Resident #3 was assessed for totally dependent with assistance by staff for toileting, bathing, and dressing. -Resident #3 was assessed for extensive assistance by staff with transferring. -Resident #3 was assessed for limited assistance by staff with eating, ambulation, and grooming. Review of the current Licensed Health Professional Support review, dated 07/02/16, revealed the use of a restraint was not documented. Interviews with Resident #3 on 07/28/16 at 11:30 am and 12:20 pm revealed: -He was feeling much better since coming to the facility. -He was not aware why the bedrails were on his bed. -He was not sure he could put the side bedrail down himself. (He was not sure how it released.)	D 484		

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D 484	Continued From page 31 - "The bedrails were a problem" and "hard to live with" because the bedrails kept him from getting out of bed. Interviews on 07/29/16 at various times 5 staff members revealed: -One staff member had not seen Resident #3 attempting to get out of bed with the bedrail up. -A second staff member stated Resident #3 had bedrails up when in bed. The staff member was instructed (do not remember by whom) that Resident #3 used the rails to help position in bed. Resident #3 had not been observed by the staff member trying to get out of bed either around or over the bedrail. Resident #3 had not mentioned that the bedrail was a problem. -A third staff member stated Resident #3 had bedrail up when in bed. The staff member was instructed (do not remember by whom) that Resident #3 used the bedrail to help position in bed. The staff member always raised the bedrail when putting Resident #3 in bed. Resident #3 had not mentioned that the bedrail was a problem. -A fourth staff member had observed Resident #3 sitting at the end of the bedrail, between the rail and the footboard with feet hanging off the side of the bed, at least 2 times during the last month. Resident #3 had not told the staff member he did not like the bedrail up. The bedrail kept the resident from falling out bed. -A fifth staff member had observed Resident #3 sitting on the end of the bed, between the rail and the foot board, ready to attempt to get up. (Not sure of an exact number of times). On at least one occasion, the staff member observed Resident #3 with an arm and leg on top of the bedrail as if preparing to climb over the rail. None of these occurrences had been in the last 3 weeks.	D 484		

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D 484	Continued From page 32 Interview on 07/28/16 at 3:00 pm with a case manager for a local branch of Hospice revealed: -Resident #3 had been receiving hospice care since arriving at the facility in 2015 (approval beginning 08/08/15) -Resident #3 had a hospital bed with full bedrails ordered by the hospice physician and provided by hospice upon arrival. -Resident #3 used the full bedrail for "safety to prevent falls". -She was not aware of a Care Plan specific to the use of bedrails for Resident #3. -She had numerous conversations and consults with the facility and Resident #3's Power of Attorney(POA)/Family Member about the siderail being up when Resident #3 was in bed for safety. -She felt Resident #3 could not put the bedrail down independently due to decrease in cognitive abilities. Telephone interview on 07/28/16 at 10:53 am with Resident #3's POA/Family Member revealed: -He was aware Resident #3 had a bedrail that staff put up when he was in bed. -He had discussed the use of the bedrail instead of a mat on the floor for safety from falling out of bed because his other family member, in the same room, might trip over the mat when it was down. -The facility had adjusted medications as the resident's health improved, and the resident was much better physically and mentally at the current time. -He did not recall assisting in developing a Care Plan specific for using the bedrail as a restraint. Interview on 07/28/16 at 3:45 m with a Co-Administrator on 07/28/16 at 3:45 pm revealed: -The facility did not use full bedrails very often.	D 484		

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-Resident #3's POA/Family Member signed the facility's form explaining the potential for siderails to be restraints in June 2015.
-Resident #3 used the bedrail primarily for assistance with positioning in the bed.
-Resident #3 had fallen out of bed at least 2 times.
-The facility had tried a floor mat beside the bed in the event the resident had a fall from bed, however the POA/Family Member did want the mat used because it posed a trip hazard to Resident #3's roommate.
-Resident #3's POA/Family Member was in agreement that the bedrail should be on the bed for safety.
-The facility had an assessment form (Physical Restraint Elimination Assessment) used by the Co-Administrator to evaluate if the resident should have the bedrail.
-She would be responsible to assure proper documentation for the use of bedrails as a restraint.
-She was not aware of the documentation requirements for the use of restraints.

Telephone interview on 07/29/16 at 9:34 am with Resident #3's primary care provider nurse revealed:
-The facility was faxed an order for bedrails on 07/28/16.
-The facility would be responsible for completing any required assessments and notifying the physician if needed.

Second interview on 07/29/16 at 10:30 am with Resident #3's POA/Family Member revealed:
-He did not want the bedrail removed for the resident.
-He would be glad to assist the facility with any documentation required to assure compliance

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D 484	Continued From page 34 with requirements or regulations. He was at the facility every day and checked on the family member. -He did not consider the bedrail a restraint but considered it a safety device to help remind the resident he needed assistance getting out of bed. -Resident #3 had never complained to the POA about the bedrail being a problem.	D 484		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to performing wound care to a resident with a Stage IV wound. The findings are: A. Based on observations, interviews, and record reviews, the facility failed to ensure non-licensed staff were competency validated to apply debriding agents (Medihoney and Santyl) to a pressure ulcer for 1 resident (Resident #5) and prior to performing wound care and packing of wounds for 1 resident (Resident #4) with Stage IV pressure ulcers. [Refer to Tag 0163, 10A NCAC	D912		

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D912	Continued From page 35 13F .0504(c) (Type B Violation).]	D912		