STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056006	A. BUILDING: _____ B. WING _____	R-C 03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN HOUSE	186 ONE CENTER STREET FRANKLIN, NC 28734

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D 000	Initial Comments The Adult Care Licensure Section and the Macon County Department of Social Services conducted an annual survey, follow-up survey, and compaint investigation on March 13, 2018 through March 15, 2018.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews the facility failed to ensure referral and follow up to meet the routine and acute health care needs for 1 of 8 (Resident #6) sampled residents related to the monitoring, assessment, and follow-up of a leg wound. The findings are: Review of Resident #6's current FL-2 dated 7/11/17 revealed: -Diagnoses included Alzheimer's dementia, chronic obstructive pulmonary disease, a history of falls, back pain, constipation, and hypertension. -Resident #6 was documented as non-ambulatory and incontinent of bowel and bladder. Review of Resident #6's Resident Register revealed she was admitted to the facility on	D 273		

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D 273	Continued From page 1 7/18/16. Review of the current Licensed Health Professional Support evaluation dated 11/27/17 revealed: -Resident #6 was alert with confusion. -Resident #6 was receiving palliative care services. -Resident #6 used oxygen at 2 liters per minute via nasal cannula. -Two staff members were required for transfers. Review of Resident #6's current Care Plan dated 7/7/17 revealed extensive assistance was required for bathing, dressing, toileting, transfers, and feeding assistance. Telephone interview on 3/5/18 at 1:15pm with Resident #6's family member revealed: -The family member had visited with Resident #6 on 2/2/18 during the evening meal. -A facility staff member informed the family member that Resident #6 had been in bed all day. -The staff member asked the family member to look at Resident #6's leg. -The family member took a picture of a wound on the leg and sent it to the family member's physician. -The family member requested the facility send Resident #6 to the emergency room (ER). -Resident #6 was admitted to the hospital for medical treatment and discharged to a higher level of care facility on 2/5/18. -"There is no communication between shifts." -"The facility is supposed to call me if (Resident #6) did not get up for lunch and no one called me that day." -Resident #6 was tested for MRSA (Methicillin-Resistant Staphylococcus, a bacteria)	D 273		

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D 273	Continued From page 2	D 273		

in the wound and it was positive.
-"The staff at the facility was putting Neosporin (antibiotic) on the leg and (Resident #6) was allergic to Neosporin."

Review of Resident #6's medical record revealed:
-Resident #6 had a history of a Stage IV pressure ulcer on the thoracic spine that had healed.
-There was a physician order dated 1/19/18 for dressing changes two times per day to the left lower leg; wash with warm water and soap, apply antibiotic ointment, and redress twice daily and as needed for soiling.
-There was documentation by staff on 2/1/18; "wounds on lower legs not looking any better and have gotten worse. Placing resident on PCP (primary care physician) list for next facility day (2/6/18)".
-There was documentation by staff on 2/2/18;"resident's leg wounds discovered by family and they requested resident be sent to the emergency room (ER) Family present and PCP notified.".
-There was no documentation of an assessment of the leg by the facility Registered Nurse or the facility Nurse Practitioner (NP).

Review of the ER history and physical on 2/2/18 for Resident #6 revealed:
-Resident #6 came to the ER from the facility with pain in the lower extremity.
-Resident #6 had not been out of bed all day due to pain in the lower extremity.
-A family member had found a large ulcer on the lower right lateral ankle after the sock had been removed.
-A tube of triple antibiotic ointment (Neosporin) was on the bedside table and the wound had been covered with a dressing.
-Resident #6 was allergic to Neosporin antibiotic.

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D 273	Continued From page 3	D 273		

-The wound was an unstageable decubitus ulcer on the ankle.
-There was no documented duration of the ulceration.

Review of the hospital history and physical for Resident #6 revealed:
-Resident #6 was admitted to the hospital for intravenous antibiotics and aggressive wound care for the infected ulcer on the right lateral ankle.
-There was documentation by a physician that Resident #6 was at risk of worsening ulcer with gangrene, sepsis syndrome, worsening debility and death.

Review of the hospital lab record for Resident #6 revealed the wound culture was positive for MRSA.

Interview on 3/13/18 at 4:10pm with the facility Nurse Practitioner (NP) revealed:
-A telephone order was given on 1/19/18 for dressing changes twice per day to the left lower leg including to wash the leg with warm water and soap.
-The order was signed the next time the she was in the facility on 1/23/18.
-She did not assess or look at the wound on 1/23/18 when she was in the facility.

Interviews on 3/14/18 at 9:00am and 3/15/18 at 9:10am with first shift medication aide (MA) revealed:
-The MA and another staff member had discovered the wound on Resident #6's leg on 1/19/18 during a bath.
-The wound looked like a scab near the sock line.
-The MA informed the Special Care Coordinator (SCC).

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D 273	Continued From page 4	D 273		

-The SCC obtained a telephone order to put ointment and dressings on it.
-The wound looked the size of a nickel for about a week and a half.
-The MA changed the dressing every day when assigned to Resident #6.
-The MA wound initial the new dressing when it was changed.
-"In January when the dressing was changed, the wound looked like a skin tear, it had scabbed over."
-"It looked smaller than a dime."
-When the wound dressing was changed on 2/1/8 it looked no different.

Interviews on 3/14/18 at 9:10am and 3/15/18 at 9:20am with a second first shift MA revealed:
-The MA helped with the dressing changes to Resident #6's leg.
-The wound looked like a scab.
-The MA would clean the wound with a facility house stock dermal wound cleanser, apply antibiotic ointment, and apply a bandange.
-The MA changed the bandage on 2/2/18 and it appeared to be "scabbing over" with no drainage.
-The SCC did not look at the wound because he "did not have to, it wasn't necessary".

Interview on 3/14/18 at 10:50am with a first shift personal care assistant (PCA) revealed:
-She had given Resident #6 a bed bath on 1/29/18.
-The bandage on the resident's leg had come off.
-"It (wound) looked bad."
-The PCA reported the wound to the MA on duty.
-The MA looked at the wound and "bandaged it back".
-The wound "looked yellow with drainage on the scab".
-The protocol when a wound was discovered was

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D 273	Continued From page 5	D 273		

to inform the MA and the MA would inform the SCC.

Interview on 3/14/18 at 11:45am with a second first shift PCA revealed:
-The PCA was helping with the bed bath on 1/29/18.
-"The sore on the ankle did not look well, but not horrible."
-"It looked more like a water blister about the size of a 50 cent piece."
-The PCA gently washed the wound and the MA put on the ointment and bandage.
-The wound "looked red, yellow, with drainage on it. It looked like a skin tear.".

Interview on 3/14/18 at 3:10pm with a second shift PCA revealed:
-The PCA had given Resident #6 a bed bath on 1/15/18.
-There was no wound on the leg.
-The PCA had not given any other baths to Resident #6.

Interview on 3/14/18 at 3:40pm with a second shift MA revealed:
-The MA did the dressing change on the day it was ordered, 1/19/18.
-The wound was red and swollen and starting to scab over.
-The MA was "surprised it got worse all of a sudden".
-The MA had received no reports from staff that the wound was worse.

Interview on 3/14/18 at 4:00pm with a second, second shift MA revealed:
-The MA saw the wound on 2/1/18 and it looked "redder".
-The MA took a picture of the wound and sent it to

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D 273	Continued From page 6	D 273		

the SCC who was not in the facility.
-The Resident Care Coordinator (RCC) was notified of the wound.
-The RCC put Resident #6 on the list to be seen by the NP on the next scheduled facility visit (2/6/18).
-The MA saw the wound on 2/2/18 and it "looked redder and had gotten bigger and had some drainage".
-The MA took Resident #6's temperature and it was "slightly up".
-The MA knew the resident needed to be sent to the hospital.
-Resident #6's family member requested Resident #6 be sent to the hospital for treatment.

Interview on 3/15/18 at 12:15pm with the SCC revealed:
-The wound on Resident #6's leg was discovered by staff and brought to his attention.
-The wound looked "like a skin tear".
-The SCC received a telephone order on 1/19/18 for dressing changes three times daily.
-The SCC looked at the wound a week later and there were no changes.
-He had not documented an assessment of the wound.
-The SCC could not "stop and look at every little thing".
-The facility staff notified him on 2/1/18 while at home of the wounds worsening condition.
-The staff put Resident #6 on the PCP list to be seen on the next regular scheduled visit, 2/6/18.
-"The wound looked bad, but I thought it was going to be a couple of days for the PCP to be in the facility."
-The family member of Resident #6 came into the facility on 2/2/18 and wanted the resident sent to the hospital.

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D 273	Continued From page 7	D 273		

Telephone interview on 3/15/18 at 2:05pm with a consulting physician revealed:
-The physician was consulted from a request by Resident #6's family member.
-The physician was sent a picture on of Resident #6's leg wound by the family member.
-The physician advised the family member the resident needed to be sent to the hospital after viewing the picture.
-"The wound was nothing that would happen overnight or in a couple of days. The wound had been there for a week or weeks, long term."
-Resident #6 "is a high risk patient for skin breakdown because of her history of skin ulcers".
-"The wound was deep and it looked awful and it wasn't nickel size, it was bigger."

Attempted telephone interview on 3/15/18 at 2:30pm with the ER physician was unsuccessful.

Attempted telephone interview on 3/15/18 at 3:00pm with the primary care physician was unsuccessful.

Telephone interview on 3/16/18 at 12:56pm with the ER consulting physician's medical assistant revealed:
-Resident #6 had vascular insufficiency and was not getting enough blood flow to the wound for it to heal.
-Resident #6 was at risk for amputation if the wound was not healed.
-Resident #6 was allergic to Neosporin and the facility was using it on the wound.

Interview on 3/15/18 at 12:15pm with the Administrator revealed:
-A telephone order was received from the physician on 1/19/18 for dressing changes.
-There was no other note in Resident #6's

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D 273	Continued From page 8	D 273		

medical record until 2/1/18 which stated the wound looked worse.
-Resident #6 was placed on the PCP list for next time she was in the facility (2/6/18).
-"It was (name of SCC) job to assess the wound, but this was not done."
-The SCC was a registered nurse.

Request for a Wound Care Policy and Procedure was not provided by the facility.

The failure of the facility to ensure referral and follow-up for wound care and assessment for 1 of 8 sampled residents (#6) increased the risk of infection, sepsis, amputation and possible death. The facility failed to ensure the safety and well-being of Resident #6 by not monitoring the progression of the wound and seeking medical attention, resulting in her admission to the hospital for treatment of the wound, and discharged from the hospital to a higher level of care. These failures resulted in an infected decubitus ulcer and placed Resident #6 at substantial risk of serious medical harm including death and amputation and constitutes a Type A1 Violation.

A Plan of Protection provided by the facility on 3/14/18 revealed:
-Upon notification of wound to the Administrator on 2/6/18 a stand up meeting was held addressing the lack of reporting.
-The Administrator discussed the importance of reporting any changes in skin integrity or concerns noted by caregivers.
-The Care Managers are then to report changes to the Primary Care Physician or provide additional options to the resident and responsible

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D 273	Continued From page 9 party. -A mandatory staff meeting scheduled prior to 3/31/18 to discuss the importance of; reporting any health concerns or changes in resident health to the care management, care management to make referral for any health concerns including wounds to proper agnecy, a timely follow-up with the Primary Care Physician or proper agency. -The care management to obtain copies for all shower or body evaluations with verbal follow up with staff on any changes in skin integrity on a weekly basis. -The Administrator to review any voice concerns with care management on a weekly basis during scheduled stand up meetings. _____ CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 14, 2018	D 273		
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 interviews and record reviews the facility failed to ensure referral and follow up to meet the routine and acute health care needs for 1 of 8 (Resident #6) sampled residents related to the monitoring, assessment, and follow-up of a leg wound.	D912		

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D912	Continued From page 10 The findings are: Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the routine and acute health care needs for 1 of 8 sampled residents (#6) related to the monitoring, assessment, and follow-up of a leg wound. [Refer to Tag 0273 10A NCAC 13F.0902(b) Health Care (Type A1 Violation).].	D912		