

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

PRINTED: 03/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/08/2012
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NAME OF PROVIDER OR SUPPLIER MOUNTAIN TRACE REHABILITATION & NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 417 MOUNTAIN TRACE ROAD SYLVA, NC 28779
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F 157 SS=G	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to notify the physician of changes in</p>	F 157	<p>Plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of Federal and State law.</p> <p>Resident #1 no longer resides at the facility.</p> <p>Residents experiencing a change of condition have the potential of being affected by this deficient practice although none were found to be affected.</p> <p>An audit of current resident medical records to be completed by 3/20/12 to ensure changes of condition have been identified and physician and/or responsible party notification completed. Education provided to the licensed nursing staff on 3/25/12 by the Director of Nursing regarding the policy and procedure for physician and/or responsible party notification regarding changes in resident condition.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Glenn D Elliott* TITLE Administrator (X6) DATE 3-29-12

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 required to be completed.

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F 157	<p>Continued From page 1</p> <p>pressure ulcers for one (1) of ten (10) sampled residents. (Residents #1).</p> <p>The findings are:</p> <p>Resident #1 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease, high risk for skin breakdown, and diabetes. The admission Minimum Data Set (MDS) dated 01/11/12 indicated cognition was moderately impaired and the resident required extensive staff assistance for transfers, eating, dressing and personal hygiene. The MDS specified Resident #1 was admitted to the facility with one (1) Stage II pressure ulcer and two (2) unstageable pressure ulcers with suspected deep tissue injury.</p> <p>A Care Area Assessment (CAA) dated 01/16/12 specified Resident #1 entered the facility with a Stage II pressure ulcer to the coccyx and blisters to both heels. The CAA continued Resident #1 was at risk for complications, further breakdown, and infection. The CAA also specified further skin breakdown would be evaluated by the physician for possible changes to the resident's care.</p> <p>The resident's care plan dated 01/22/12 identified skin breakdown of a Stage II coccyx pressure ulcer and blisters on both heels. The care plan goal specified the resident would be free from further pressure areas through the next three (3) months. Interventions for this care plan included initiate skin treatments as ordered and inform the physician of signs and symptoms of skin breakdown.</p>	F 157	<p>(Continue)</p> <p>Education provided to the licensed nursing staff by Lorelei Yerse, BSN, RN, CWOCN on 4/4 and 4/5/12 regarding the necessity of physician notification of changes in resident's pressure ulcers. No licensed nursing staff will be allowed to work until this education is completed. This same education to be provided to new employees upon hire. 24hr reports to be reviewed daily M-F with weekend reports being reviewed on Monday during the morning clinical meeting and follow up completed to ensure notification of physician has occurred for any changes in condition. Review of physician telephone orders daily M-F with weekend orders being reviewed on Monday during the morning clinical meeting and follow up completed to ensure notification of physician has occurred.</p> <p>Unit Managers to complete daily audits (M-F) x 4 weeks, weekly x 4 weeks and monthly ongoing of the 24hr report to ensure notification has been completed and documented on QA audit tool.</p> <p>ADON/DON to complete 2 random chart audits daily M-F x 2 weeks, then weekly x 2 weeks then monthly ongoing to ensure appropriate notification of changes in condition have been completed.</p> <p>Findings from the QA audits will be presented to the QA committee by the DON monthly x 3 then quarterly thereafter to determine the need for additional education and/or monitoring.</p> <p>Compliance date 4/5/12.</p>		

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F 157	<p>Continued From page 2</p> <p>A review of a medical progress note dated 01/30/12 revealed the Family Nurse Practitioner (FNP) examined Resident #1 on this date. The document specified the purpose of the medical visit was to evaluate the resident due to nursing concerns secondary to fever, worsening heel ulcers, and mental status change. Wound measurements for the heels were documented as follows: The left heel wound measured 4.7 x 5 centimeters (cm). The right heel wound measured 6.1 x 5 cm. Both heel wounds were described oozing brown pus-like drainage. An odor was noted with all wounds.</p> <p>Continued medical record review revealed a nursing note dated 01/30/12 at 1:35 PM signed by Licensed Nurse (LN) #3. The note described Resident #1 as lethargic and having a temperature of 99.5 degrees Fahrenheit. The note specified the resident was examined by the FNP and sent to an acute care facility for evaluation for sepsis related to wound status and mental status changes.</p> <p>A review of a wound care clinic evaluation obtained in the acute care facility and dated 01/31/12 described the wounds as follows: The left heel wound measured 3.5 x 5 x 0.2 cm. The wound was described as a pressure ulcer with necrotic tissue and blister membranes and was unable to be staged. The right heel wound measured 8 x 5 x 0.2 cm. The wound was described as a pressure ulcer with purulent drainage and unable to be staged.</p> <p>A review of a discharge summary from the acute care facility dated 02/03/12 revealed discharge diagnoses included: 1. Bacterial aspiration</p>	F 157		
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F 157	Continued From page 3 pneumonia. 2. Decubitus both heels and coccyx with one wound showing bacterial infection. An interview on 03/08/12 at 11:45 AM with LN #2 revealed she worked on 01/18/12 when the blisters on both of Resident #1's heels were observed opened and stated she did not notify the physician or the FNP. An interview on 03/08/12 at 11:59 AM with the FNP revealed she was not contacted on 01/18/12. An interview on 03/08/12 at 4:30 PM with the Administrator revealed the nurse should have notified the physician or FNP on 01/18/12 when the resident's heel wounds opened. An interview on 03/08/12 at 11:44 AM with the resident's physician revealed he expected to be notified by facility staff anytime a resident's wound was getting worse.	F 157		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by:	F 314	See next page	

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F 314	<p>Continued From page 4</p> <p>Based on observations, record reviews and staff interviews, the facility failed to assess, monitor and treat pressure ulcers for two (2) of ten (10) sampled residents. (Residents #1 and #7).</p> <p>The findings are:</p> <p>Facility policies entitled Protocols for Wound Care and Prevention, Treatment of Pressure Sores, and Skin Care Prevention Protocol dated 12/04/00 were reviewed. The documents contained the following: All pressure ulcers will be reevaluated and measured weekly. Pressure ulcer documentation will include location and staging, size, description of exudate, if present, wound bed, wound edges and surrounding tissue. Residents at risk for heel ulcer formation require weekly assessments.</p> <p>1. Resident #1 was admitted to the facility with diagnoses including; chronic obstructive pulmonary disease, high risk for skin breakdown, and diabetes.</p> <p>The admission Minimum Data Set (MDS) dated 01/11/12 indicated cognition was moderately impaired and extensive staff assistance was required for transfers, eating, dressing and personal hygiene. The MDS specified Resident #1 was admitted to the facility with one (1) Stage II pressure ulcer and two (2) unstageable pressure ulcers with suspected deep tissue injury.</p> <p>A Care Area Assessment (CAA) dated 01/16/12 specified Resident #1 entered the facility with a Stage II pressure ulcer to his coccyx measuring 2.0 x 0.1 x 0.1 centimeters (cm). The resident also had blisters to both heels. The CAA</p>	F 314	<p>F314- Pressure ulcers</p> <p>Resident #1 no longer resides at the facility. Resident #7 has been receiving weekly assessments, measurements and appropriate documentation of his pressure ulcer, by the Assistant Director of Nursing. Updated physician orders regarding the treatment for resident #7's pressure ulcer have been obtained and are being followed by the Assistant Director of Nursing.</p> <p>Residents with pressure ulcers have the potential of being affected by this deficient practice although none were found to be affected.</p> <p>An audit of current residents with pressure ulcers was completed by the Wound Care Team, (DON, ADON, Unit Managers, Wound Nurse, Therapy Director, and Administrator, on 3/30/12 to ensure wounds have been thoroughly assessed, measured, documented, treated and notification of changes to physician and/or responsible parties have been made. Education to nursing staff on 4/4 and 4/5/12 provided by Lorelei Yerse, BSN, RN, CWOCN regarding the prevention, identification, assessment, monitoring and treatment of pressure ulcers. The need for notification of the physician with changes to a pressure ulcer was also included in this education. This same education will be provided to new employees upon hire. No nursing staff employees will be allowed to work until this education is completed. Copies of Wound Care protocol have been placed in each treatment book for the licensed nursing staff to refer to.</p>	

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F 314	<p>Continued From page 5</p> <p>continued Resident #1 was at risk for complications, further breakdown, and infection. The resident would have routine skin audits to ensure there was no further breakdown and the areas were healing appropriately without complications. The CAA also specified further skin breakdown would be evaluated by the physician for possible changes to the resident's care.</p> <p>The resident's care plan dated 01/22/12 identified skin breakdown of a Stage II coccyx pressure ulcer and blisters on both heels. The care plan goal specified the resident would be free from further pressure areas through the next three (3) months. Interventions for this care plan included initiate skin treatments as ordered, skin assessment weekly, and inform the physician of signs and symptoms of skin breakdown.</p> <p>a. A review of Resident #1's medical record revealed a nursing note dated 01/18/12 written by Licensed Nurse (LN) #2 at 2:00 PM. The note specified open sores on both heels were noted today and painted with a prodine-iodine antiseptic, foam was applied and wrapped with gauze.</p> <p>No further assessment or measurements of "open sores" to the resident's heels was documented in the medical record between 01/18/12 to 01/30/12.</p> <p>A review of a medical progress note dated 01/30/12 revealed the Nurse Practitioner (FNP) examined Resident #1 on this date. The document specified the purpose of medical visit was to evaluate the resident due to nursing</p>	F 314	<p>New admissions will be reviewed by the Clinical Wound Nurse in the morning clinical meeting daily M-F to ensure Initial skin assessments are completed and necessary treatments ordered. Weekend admissions will be reviewed by the weekend supervisor. Treatment Records will be audited daily M-F x 4 weeks, weekly x 4 weeks then monthly ongoing by the Unit managers to ensure appropriate treatments have been completed as ordered. ADON/DON will review Unit manager's daily audits weekly x 4 weeks then monthly thereafter with appropriate follow up provided. Unit Managers will conduct an audit daily x 4 weeks, weekly x 4 weeks then monthly thereafter of the weekly skin assessments for completion and document their findings on a QA audit</p> <p>tool. ADON/DON will review these audits weekly and appropriate follow up provided. A clinical wound specialist, BSN, RN, WCC from American Medical Technologies, made wound rounds with facility wound team on 3/22/12 and will continue monthly to offer additional education and resources to assist in wound healing. The wound team consists of: DON, ADON, Unit Managers, wound nurse, Therapy Director and Administrator.</p> <p>New experienced wound nurse, RN to begin on 4/2/12.</p> <p>The wound team will attend training provided by the North Carolina Quality Improvement Organization on April 11, 2012.</p>	
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F 314	<p>Continued From page 6</p> <p>concerns secondary to fever, worsening heel ulcers, and mental status change. Wound measurements for the heels were documented as follows: The left heel wound measured 4.7 x 5 cm. The right heel wound measured 6.1 x 5 cm. Both heel wounds were described oozing brown pus-like drainage. An odor was noted with all wounds.</p> <p>Continued medical record review revealed a nursing note dated 01/30/12 at 1:35 PM signed by LN #3. The note described Resident #1 as lethargic and having a temperature of 99.5 degrees Fahrenheit. The note specified the resident was examined by the FNP and sent to an acute care facility for evaluation for probable sepsis of wounds, early pneumonia and mental status changes.</p> <p>A review of a wound care clinic evaluation obtained in the acute care facility and dated 01/31/12 described the wounds as follows: The left heel wound measured 3.5 x 5 x 0.2 cm. The wound was described as a pressure ulcer with necrotic tissue and blister membranes and was unable to be staged. The right heel wound measured 8 x 5 x 0.2 cm. The wound was described as a pressure ulcer with purulent drainage and unable to be staged.</p> <p>A review of a discharge summary from the acute care facility dated 02/03/12 revealed discharge diagnoses included: 1. Bacterial pneumonia. 2. Decubitus both heels and coccyx with one wound showing presence of bacteria.</p> <p>An interview on 03/06/12 at 12:31 PM with the FNP revealed she was asked by the facility</p>	F 314	<p>Findings from the QA audits will be presented to the QA committee by the DON monthly x 3 months then quarterly thereafter to determine the need for additional education and/or monitoring.</p> <p>Compliance will be on 4-5-12</p>	
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F 314	<p>Continued From page 7</p> <p>wound nurse to examine Resident #1 on 01/30/12 related to altered mental status and fever. She stated foul odor was noted in the room. The wound nurse undressed the heel wounds and they appeared as described in her written report. The FNP stated this was the first time she had been asked to examine the resident's wounds.</p> <p>b. A review of a facility document dated 01/27/12 revealed measurements of Resident #1's coccyx wound on that date was 1 x 0.2 x 0.1 cm. No further description of the wound was provided. No other measurements or assessments of the coccyx wound were found on the medical record between the dates of 01/16/12 and 01/27/12.</p> <p>A review of a medical progress note dated 01/30/12 revealed the Nurse Practitioner (FNP) examined Resident #1 on this date. The document specified the purpose of medical visit was to evaluate the resident due to nursing concerns secondary to fever, worsening heel and coccyx ulcers, and mental status change. Further review of the medical progress note revealed the coccyx wound measured 8 x 8.4 cm and was described draining yellow pus and an odor was noted.</p> <p>Continued medical record review revealed a nursing note dated 01/30/12 at 1:35 PM signed by LN #3. The note described Resident #1 as lethargic and having a temperature of 99.5 degrees Fahrenheit. The note specified the resident was examined by the FNP and sent to an acute care facility for evaluation related to wound status and mental status changes.</p>	F 314		
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F 314	<p>Continued From page 8</p> <p>A review of a wound care clinic evaluation obtained in the acute care facility and dated 01/31/12 specified the coccyx wound measured 10 x 8.5 x 0.2 cm. The wound was described as a pressure ulcer with 40 percent slough, drainage, and unable to be staged.</p> <p>A review of a discharge summary from the acute care facility dated 02/03/12 revealed discharge diagnoses included: 1. Bacterial aspiration pneumonia. 2. Decubitus both heels and coccyx with one wound showing presence of bacteria.</p> <p>An interview on 03/06/12 at 12:31 PM with the FNP revealed she was asked by the facility wound nurse to examine Resident #1 on 01/30/12 related to altered mental status and fever. She stated foul odor was noted upon entering the room. The wound nurse undressed the coccyx wound. The wound appeared as described in her written report. The FNP stated this was the first time she had been asked to examine the resident's wounds.</p> <p>An interview on 03/06/12 at 2:20 PM with LN #9 revealed he did the dressing change to the coccyx wound on 01/28/12 which was the last documented dressing change before 01/30/12. He stated the coccyx wound did not have an odor or drainage.</p> <p>2. Resident #7 was admitted to the facility 07/29/11 with diagnoses including failure to thrive, congestive heart failure, hypertension and Alzheimer's disease.</p> <p>A quarterly Minimum Data Set (MDS) dated 01/24/12 indicated the resident was severely</p>	F 314		

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F 314	<p>Continued From page 9</p> <p>cognitively impaired and required extensive staff assistance with mobility, transfers, dressing, and personal hygiene. The MDS noted the resident had one (1) unhealed Stage II pressure ulcer that was present upon admission.</p> <p>A care plan updated 01/26/12 identified the resident was at risk for skin breakdown. The care plan goal specified the resident would experience no further skin breakdown. Interventions included treatments/dressing changes as ordered, update physician as needed, initiate skin treatments as indicated/ordered, skin assessment weekly, and inform physician of signs and symptoms of skin breakdown.</p> <p>Medical record review revealed the last documented wound assessment and measurement of the pressure ulcer was prior to January 2012.</p> <p>A review of Resident #7's medical record revealed a physician's order dated 01/27/12. The order specified to cleanse the left hip wound with normal saline, dry, apply an island dressing every three days and as needed.</p> <p>A review of Resident #7's Treatment Record (TAR) revealed the hip wound treatment was initialed as completed on 02/27/12. A review of the March 2012 TAR revealed no initials to indicate the dressing was changed during this month.</p> <p>An observation was conducted on 03/06/12 at 4:28 PM of Unit Manager (UM) #1 performing a dressing change on Resident #7's left hip. UM #1 was observed to remove the old hip dressing.</p>	F 314		
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(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 314	<p>Continued From page 10</p> <p>The dressing was dated 02/27/12. At that time UM #1 verified the date of 02/27/12 on the removed dressing. The old dressing contained an approximate quarter size amount of dried brown colored drainage when removed. The wound bed was observed red in color and approximately the size of a quarter with superficial depth. The skin immediately surrounding the wound was pink in color. The dressing change was completed as ordered.</p> <p>During an interview on 03/07/12 at 11:20 AM, UM #1 stated prior to 03/06/12 Resident #7's dressing was last changed on 02/27/12. She stated the dressing should have been changed on 03/01/12 and on 03/04/12 per physician's orders.</p>	F 314		