STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: 345092

MULTIPLE CONSTRUCTION
A. BUILDING _____________________________
B. WING _____________________________

DATE SURVEY COMPLETED: 02/26/2014

NAME OF PROVIDER OR SUPPLIER

WINSTON SALEM NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

1900 W 1ST STREET
WINSTON-SALEM, NC  27104

ID PREFIX TAG
F 328

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS

The facility must ensure that residents receive proper treatment and care for the following special services:
Injections;
Parenteral and enteral fluids;
Colostomy, ureterostomy, or ileostomy care;
Tracheostomy care;
Tracheal suctioning;
Respiratory care;
Foot care; and
Prostheses.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, resident interview and staff interviews the facility failed to follow a doctor's order for 1 of 1 sampled resident (Resident # 6) who had a doctor's order for a podiatrist.

The findings included:
Resident #6 was admitted to the facility on 1/16/14 with a diagnosis that included, end stage renal disease, diabetes, hypertension, anemia, dysphasia, and peripheral vascular disease.

Review of Resident #6 medical record revealed a physician order dated 1/17/14 dictating, "Referral to podiatrist."

Review of the most recent Minimum Data Set Assessment (MDS) dated 1/28/14 indicated Resident #6 required limited to extensive assistance to complete activities of daily living (ADLs). Resident #6 was further coded on the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE  DATE

Electronically Signed  03/22/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

If continuation sheet Page  1 of 6

Facility ID: 923570

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
PRINTED: 06/20/2014
FORM APPROVED
OMB NO. 0938-0391

EVENT ID: 62RG11

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<td>F 328</td>
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<td>Continued From page 1 MDS as being cognitively intact. Review of Resident #6 treatment record for the month of January 2014 indicated; podiatrist consult. There was no documentation recorded on the treatment record that indicated Resident #6 received a podiatry consult. Review of the treatment record for Resident #6 for the month of February indicated; podiatrist consult. There was no documentation recorded on the treatment record that indicated Resident #6 received a podiatry consult. Review of Weekly Skin assessments dated 1/17/14 revealed Resident #6 had long thick toenails. Further review of Weekly Skin assessment dated 2/3/14, 2/10/14, and 2/24/14 did not make mention to the condition of Resident #6 feet. Observation on 2/25/14 at 3:20 pm revealed Resident #6 lying in bed. Resident #6 toenails were observed to be long, thick, and curing upward. Some of Resident #6 toenails were 1 ½ inch long and with tips of toenails touching. Interview with Resident #6 on 2/25/14 at 3:30 pm revealed he had not refused to see a podiatrist. Resident #6 stated he was told by the facility nurses that they did not have the tools to cut his feet and they would send him out to a podiatrist. Resident #6 indicated he's feet bothered him and hurt. Resident #6 further indicated his shoes were tight around his toes and they were beginning to be too small. Resident #6 revealed his feet feel better when he does not have shoes on. Resident #6 stated he wanted to have his toenails cut.</td>
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Interview with Nurse #1 on 2/25/14 at 4:00 pm revealed she provided Resident #6 with his initial admission assessment. Nurse #1 described Resident #6 toenails as long and thick. Nurse #1 stated that when initially assessed Resident #6 she recalled him wanting his toenails cut. Nurse #1 indicated she did not have the instruments to provide Resident #6 with toenail care. Nurse #1 stated she wrote the order 1/17/14 for Resident #6 to receive a podiatry consult. Nurse #1 indicated it was her expectation for Resident #6 to have an appointment made to see the podiatrist within a couple weeks of the physician order date. Nurse #1 further indicated she had not followed up the staff #1 in regards to the scheduling of Resident #6 podiatry appointment.

In an interview with Staff #1 on 2/26/14 at 9:09 am revealed when a resident is newly admitted to the facility, she either goes through the resident's chart to determine if they have follow-up appointment or the unit manager would communicate a need for an appointment as evidenced by a physician order. Staff #1 stated that she sets up resident appointments at the time she receives the physician order. Staff #1 stated she was unaware of the physician ordered dated 1/17/14 that dictated Resident #6 was to be seen by podiatry. Staff #1 stated she had made Resident #6 podiatry appointment prior to the 2/17/14.

Interview with Nurse #2 on 2/26/14 at 11:44 am revealed she provided Resident #6 with weekly skin assessments. Nurse #2 indicated that resident feet included when weekly skin assessments are completed. Nurse #2 further described Resident #6 toenails as long and thick with fungus underneath. Nurse #2 stated on 2/25/14 Resident #6 indicated his shoes were too
F 328 Continued From page 3
small and he needed a bigger size.

Interview with Nurse #3 on 2/26/14 at 10:17am revealed there was a podiatry consult written for Resident #6. Nurse #3 indicated nursing would provide Staff #1 with a written order for consult needs. Staff #1 was responsible for making the appointments and putting them on schedule for transportation.

Interview with Nurse #4 on 2/26/14 at 10:37 am revealed that upon admission Resident #6 was provided with a podiatry consult. Nurse #4 described Resident #6 toenails as long and thick and unsafe for the facility to attempt to cut. Nurse #4 stated Staff #1 was responsible for scheduling appointments as evidence as utilizing a physician order. Nurse #4 revealed she had observed Resident #6 toenails on 1/17/14. Nurse #4 described Resident #6 toenails as very thick, growing upward, brittle, and some toenails being 1 1/2 inch long. Nurse #4 indicated the in-house podiatrist would be in the facility to provide care on his next visit cycle which is in March. Nurse #4 indicated that an appointment made a month within schedule would have been fairly reasonable.

In an interview with the Director of Nursing (DON) on 2/26/14 at 11:30 pm revealed she observed Resident #6's feet on day 2 following his admission. The DON described Resident #6's toenails as very un-kept, very long and dry. The DON stated it was her expectation that a resident with foot concerns be seen as soon as possible. The DON stated that the facility would have to take the first available appointment that did not conflict with the Resident #6 dialysis schedule which is 3 days a week. The DON further stated...
### WINSTON SALEM NURSING & REHABILITATION CENTER

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<td>that an appointment was made for Resident #6 as soon as one was available.</td>
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<td>F 328</td>
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<td>Review of the appointment log revealed Resident #6 had an appointment made for 3/6/14.</td>
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<td>Interview with an outside podiatry clinic on 2/26/14 at 3:50 pm revealed they were contacted by the facility for an appointment for Resident #6 on 2/25/14 at 1:15pm</td>
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<td>Interview with the Nurse Aide (NA) #1 on 2/26/14 at 11:44 am revealed she was assigned to provide care for Resident #6. NA #1 revealed resident toenails were in need of cutting. NA #1 recalled inquiring when the in-house podiatrist was visiting the facility and she asked Nurse #4. NA #1 stated Nurse #4 stated there was nothing that could be done to Resident #6 toenails until the in-house podiatrist returned in March. Nurse Aide #1 described Resident #6 toenails as very long and curled upward.</td>
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<td>Interview with the Social Worker Director on 2/26/14 at 4:20 pm revealed she was aware of Resident #6 needs for podiatry as evidenced by a phone call she received from Resident #6 dialysis center. The Social Worker Director continued that she inquired with the unit manager in regards to identify if Resident #6 was on the list to see the in-house podiatrist. The Social Worker Director continued that the unit manager communicated that Resident #6 was on the list to see the in-house podiatrist in March. The social worker indicated she had not documented the conversation she had with Resident #6 dialysis center in regards to his need for foot care.</td>
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| | | In an interview with the Administrator on 2/26/14
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<td>Continued From page 5 at 4:30 pm revealed podiatry needs are assessed upon admission. The nurse conducting the assessment will notify the unit manager about the residents needs. The Administrator indicated the DON attempted to cut Resident #6 toenails but Resident #6 refused. The Administrator indicated they tried to treat Resident #6 in-house. Scheduling an appointment with an outside agency would depend on the outside agencies availability see Resident #6 due to having dialysis 3 times a week. The Administrator continued with the appointment was made and was unaware of when the podiatry appointment was made. The Administrator revealed it was her expectation that nursing prioritize resident needs.</td>
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