STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING _____ B. WING _____	C 02/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSTON SALEM NURSING & REHABILITATION CENTER	**1900 W 1ST STREET WINSTON-SALEM, NC 27104**

(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 328 SS=D	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	F 328	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Winston-Salem Nursing & Rehabilitation Center does not admit that the defiency listed on this form exists, nor does the center admit to any statments, findings, facts or conclusions that form the basis for alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." F328 1. Corrective action for resident found affected- Resident # 6 was seen by the Director of Nursing on 2/26/14 to assure comfort and no pain. Resident #6 was sent to outside Podiatrist on 3/6/14; in	3/6/14

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

Electronically Signed | 03/22/2014

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F 328	Continued From page 1 MDS as being cognitively intact. Review of Resident #6 treatment record for the moth 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.	F 328	addition the in house Podiatrist consulted with resident on 3/12/14. 2. To assure corrective action for those residents having potential to be affected- On 2/27/14 the Director of Nursing and Assistant Director of Nursing did a full house audit of residents for any identifiable toenail or fingernail abnormalities and care needs. Any findings were addressed by nursing staff and Podiatrist was notified. No resident was identified as having emergent need. 3. Systemic Changes to ensure practice will not reoccur- On 2/27/14 the Director of Nursing and Assistant Director of Nursing in-serviced nursing staff on proper identificaiton and communication of residents that presented with or complained of any abnormal toenail/fingernail issues including any pain issues related to shoes. The Wound Care Nurses were issued appropriate nail trimming equipment and will include toenails in their weekly skin assessments. Additional Systemic change-if a resident needs immediate Podiatry consult, our in-house Podiatrist will be notified and has agreed to come to facility outside of his regular quarterly scheduled visits. 4.Monitoring Process-Unit Managers, Director of Nursing and Assistant Director of Nursing will complete toenail audits weekly times 4 weeks and then monthly times two months and report results of the audit to the Administrator and Quality Assurance team at the Quality Assurance and Performance Improvement meeting times three months.	

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F 328	Continued From page 2 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 residents chart to determine if they have follow 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		

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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 felicity 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	F 328		

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F 328	Continued From page 4	F 328		

that an appointment was made for Resident #6 as soon as one was available.

Review of the appointment log revealed Resident #6 had an appointment made for 3/6/14.

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

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.

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.

In an interview with the Administrator on 2/26/14

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F 328	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.	F 328		