

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

PRINTED: 05/22/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345172</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/19/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MERIDIAN CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>707 NORTH ELM STREET HIGH POINT, NC 27262</b>		
(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 686 SS=D	<p>Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)</p> <p>§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to initiate treatment for a Stage 3 pressure ulcer for 1 of 3 (Resident # 2) sampled for pressure ulcers.</p> <p>Findings included:</p> <p>Resident #2 was admitted to the facility on 10/21/17 and was discharged to the hospital on 10/29/17 with diagnosis of: Alzheimers, parkinson's, diabetes mellitus type 2 and anxiety.</p> <p>A record review indicated there was not an admission Minimum Data Set (MDS) assessment completed.</p> <p>An admission nursing assessment dated 10/21/17 revealed Resident #2 had impaired cognition, was ambulatory, incontinent and had a pressure area to his sacrum. The initial nursing assessment did not include measurements of the</p>	F 686	<p>Nursing staff failed to obtain an order for a pressure ulcer/wound. This was an oversight/human error that the nurse failed to get an order for a wound.</p> <p>1. Nursing staff failed to obtain an order for a pressure ulcer timely. The Medical Director was made aware and treatment was received.</p> <p>2. A 100% skin check of residents was again completed 4/30/18-5/1/18 by nursing staff. Physician and families were notified of subsequent findings and appropriate treatment orders obtained. The Regional Nurse audited all current residents with wounds and all new admissions for the last 30 days to ensure that any skin concerns were addressed with physician notification and appropriate treatments in place.</p>	5/3/18	

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

TITLE

(X6) DATE

Electronically Signed

05/02/2018

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.

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F 686	<p>Continued From page 1</p> <p>wound or whether the wound was open or closed.</p> <p>A record review revealed care plans dated 10/21/17 for, in part, impaired cognition, wounds and nutritional concern. Interventions included: treatment as ordered.</p> <p>A record review revealed a Skin Integrity Report dated 10/23/17 completed by the Director of Nursing (DON) that indicated Resident #2 had a Stage 3 pressure ulcer measuring 3.0 x 4.5 cm with 75% granulation and 25% slough.</p> <p>A record review of the physician orders indicated there was not an order for treatment to the wound until 10/28/17.</p> <p>On 4/19/18 at 2:23 PM, an interview with the (DON) revealed she did not know why a treatment wasn't initiated to Resident #2's wound until 10/28/17 and she would have to research it to find out. The DON further revealed the facility did not have standing orders for wound care.</p> <p>On 4/19/18 at 2:50 PM, an interview with Nurse #1 revealed she could not recall much about this resident, but indicated that if Resident #2 had been admitted with an open area, she would have called the physician for treatment orders. Nurse #1 further revealed there were no standing orders for wound care and if residents are incontinent, a house stock cream would be used.</p> <p>On 4/19/18 at 3:10 PM, a follow up interview with the DON revealed she did not have any further information about Resident #2's wound. She further revealed she measured the wound when she returned on Monday, 10/23/17 and typically would then initiate a treatment order and let the</p>	F 686	<p>3. Center Nurse Executive was inserviced by the Regional Nurse on wounds, skin assessments, calling the MD and getting treatment orders for new skin concerns. Nursing staff was inserviced by the Center Nurse Executive on wounds, skin assessments, calling the MD and getting treatment orders. Included in the education was accurately completing the admission assessment and process to take when new skin concerns are noted to include notification to physician and obtaining appropriate treatment orders. Nursing staff was inserviced by the Center Nurse Executive on the basic wound protocol, which was initiated by the Medical Director.</p> <p>4. Orders, incident reports and skin assessments will be reviewed five times per week in clinical morning/stand-up to ensure orders are obtained timely. New admissions will be brought to the clinical morning meeting/stand-up to ensure all new wound treatments are obtained as indicated. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee by the Center Nurse Executive monthly for review.</p>		

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F 686	Continued From page 2 physician know. She stated she didn't know why she didn't initiate an order for this resident and that she may have been called to do something else and it slipped her mind. She would have assessed the wound again the following week, but the resident was transferred to the hospital.  On 4/19/18 at 3:25 PM, an interview with the physician revealed he could not recall Resident #2, but would have expected the facility put something into place if the resident was admitted with or developed a pressure area. He further revealed he could not say for sure if not initiating an order for treatment to Resident #2's wound right away would have caused the wound to worsen.	F 686			