STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING _____ B. WING _____	C 09/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK REHABILITATION CENTER	25 SUNNYBROOK ROAD RALEIGH, NC 27610

(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=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (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 (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. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to perform full body skin assessments to identify a change in skin condition which resulted in Stage 3 pressure ulcers on two toes for 1 of 3 residents reviewed for pressure ulcers (Resident #3). Findings include: Resident #3 was admitted to the facility on 6/21/18 with diagnosis to include: anemia and hypertension. Review of the resident's most recent Minimum Data Set (MDS), a 30-day assessment of 7/23/18, indicated the resident required extensive assistance of 2 or more people for bed mobility and personal hygiene, and total care of one person for bathing. The MDS indicated the resident had no pressure ulcers. During an observation of Resident #3 on 9/5/18 at 8:45am during incontinent care, the left 4th and	F 686	F686 Interventions for affected resident -Resident #3 had total body evaluation on 9/5/2018 by Director of Nursing and Wound Care Nurse with no other areas of concern noted. -MD/Family notified of change on 9/5/2018 and treatments initiated per physician's order. -Wound Nurse Practitioner was notified on 9/5/18; consult was placed for the evaluation of wound. Consult took place on 9/10/18. -Nurse #1 was in serviced immediately on skin evaluations. Reeducation was provided by Director Of Nursing and Staff Development Coordinator. -Root Cause: Nurse #1 singularly acted and violated the standard of care regarding the thorough completion of a full	9/8/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/20/2018

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	Continued From page 1 5th toes were noted to have a brownish crust from the base of the toes extending to the first joint of each toe. There was a dried brownish circle on the bottom of the sheet under the resident's left foot of approximately 2 centimeters (cm). A second observation was made with the Treatment Nurse on 9/5/18 at 11:30am. The nurse cleaned between the resident's left 4th and 5th toes with gauze saturated with normal saline. There was dried dark brown matter removed to separate the toes from each other, a minimal amount of fresh blood, and a moderate amount of golden residue on the gauze. The inner sides of each toe were noted to have open skin near the base of the toes. During an interview with the Treatment Nurse on 9/5/18 at 11:30am, she stated she was unaware of the open areas on the Resident's 4th and 5th toes. The nurse reported staff usually tells her about new areas or leave her a note. The Treatment Nurse provided measurements of the open areas on the fourth and fifth toes on Resident #3's left foot on 9/6/18 at 9:30am as: 4th inner toe measured 0.5cm long by 1.0cm wide by 0.5cm deep; the 5th inner toe measured 1cm long by 1cm wide by 1cm deep. The Treatment Nurse identified the areas as Stage 3 Pressure Ulcers. Review of the Resident's medical record revealed a progress note type of "Weekly Skin Check" dated 8/31/18 completed by Nurse #1 and indicated the skin check was completed on the resident with no new marks, bruises, wounds, or scars, and will continue to monitor. A "Weekly Skin Check" progress note dated 9/3/18	F 686	body skin evaluation. Interventions for residents identified as having the potential to be affected -All residents had the potential to be affected. -Complete “head to toe” skin assessments were performed on current residents beginning on 9/5/18 and ending on 9/6/18. Audits completed by wound nurse, Staff Development Coordinator, Director Of Nursing, and Unit Managers. No other residents were noted to be affected. Systemic changes -Licensed Nurses will perform resident skin assessments upon admission and weekly. -The wound nurse will be consulted on admissions that are found to have a wound of any type. Wound Nurse will then follow up with his or her own assessment. -During morning meeting, Interdisciplinary Team will review for the completeness of skin assessments and notes. This review will be ongoing. -Licensed staff will be in serviced by Staff Development Coordinator on how to properly complete a “head to toe” skin assessment and who to report any findings to. These in-services were completed on 9/8/18. Any new or rehired RN or LPNs will have this training during facility orientation. Monitoring of the change to sustain	

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F 686	Continued From page 2 completed by Nurse #1 revealed the skin check was completed and the Resident had a skin scrape on the right knee. Review of the Resident's Care Plan of 7/25/18 revealed a problem identified as: "Resident is at risk for impaired skin integrity r/t (related to) the potential for pressure, friction, and sheer. The resident is at risk for injury r/t fragile skin". Interventions included: "Offload potential areas of pressure routinely and pressure reduction mattress". During an interview with Nurse #1 on 9/5/18 at 11:50am, the nurse reported she completed the Resident's skin check on 9/3/18 and 8/31/18. Nurse #1 reported she did not check between the resident's toes when she completed the skin checks and was unaware there were any problems with the resident's toes. During an interview with the Director of Nursing (DON) on 9/5/18 at 12:10pm, the DON stated she expected nurses to check between residents' toes when completing the weekly skin checks and report to the supervisor and treatment nurse when areas of concern are identified, and expected NAs cleaned between toes when providing bathing and showers.	F 686	system compliance ongoing -Random “head to toe” assessments of 10% of facility residents will be conducted weekly by the wound nurse or designee and compared to the completed skin evaluations for accuracy. These audits will continue weekly times one month and then monthly times 3 months. -The audits will be reviewed weekly in the clinical focus meetings times one month and monthly times three months. -The DON will report weekly skin evaluation audits to the Quality Assurance and Performance Improvement (QAPI) Committee monthly times three months to ensure ongoing compliance and to determine the need for future audits. The Administrator will monitor the results presented to our QAPI Committee to ensure compliance. -The Administrator is the person responsible for implementing the Plan of Correction.	