STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345009	A. BUILDING _____ B. WING _____	C 01/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT WHITAKER GLEN-MAYVIEW	513 EAST WHITAKER MILL ROAD RALEIGH, NC 27608

(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 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately code the skin assessment in the Minimum Data Set (MDS) of a resident admitted with no pressure ulcer for 1 (Resident #2) of 3 residents reviewed. Findings included: Resident #2 was admitted in the facility on 11/26/18 with a diagnosis of closed fracture to right distal femur, metastatic adenocarcinoma and Diabetes. The resident underwent a surgery for retrograde nailing (fixation method for fractures) of distal femur. The Minimum Data Set (MDS) dated 12/3/18 stated that the resident was cognitively intact, makes self-understood and had the ability to understand others. The skin conditions section of the MDS was coded that Resident #2 was admitted with 3 unstageable pressure ulcers. The admission skin assessment from 11/26/18 by Nurse #1 showed no blisters or wound from resident's right lateral heel, anterior right heel, and right leg lower lateral. A telephone interview with Nurse #1 on 1/15/19 at 3:17 PM was conducted and Nurse #1 stated that her documentation on admission notes reflected the overall skin assessment. She also stated that her initial marks on a body drawing in her admission notes would indicate presence of wounds or	F 641	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law to remove the deficiency. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. Affected resident resolution: Resident #2 "Skin re-assessments/observations were performed by the unit manager and assigned nurse on Resident #2. "Clinical Case Mix Director (CMD), Skin Integrity Nurse (SIC) and the Director of Health Services reviewed the documentation, coding and treatment plan and corrected any inaccuracies if needed at that time. Identification of other residents who could be affected:	2/10/19

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

Electronically Signed | 01/31/2019

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F 641	Continued From page 1 blisters if it were present at that time. If there were no marks on the admission notes, it only meant that there were no wounds of blisters noted. The initial Physical Therapist assessment notes on 11/27/18 did not indicate the presence of wound on the resident's right lateral heel, anterior right heel, and right leg lower lateral. There was a wound with dark area on lateral portion of upper shin identified in this assessment as written by Physical Therapist (PT). The PT was interviewed on 1/15/19 at 2 PM and she stated that there were no notes on her assessment for the presence of any wound to resident's right lateral heel, anterior right heel, and right leg lower lateral it meant she was not aware of any wound or blisters during her assessment. A History and Physical (H&P) notes on 11/26/18 written by the Doctor did not indicate any wounds or blisters. Another note written by the Physician Assistant (PA) on 11/27/18 indicated the skin was warm and dry, staples intact on the right lower leg. The PA was interviewed on 1/16/19 at 8:20 AM and pointed out her assessment notes on 11/27/18 which there were no wounds noted. The discharge summary from the hospital did not indicate any blisters or wounds on resident's right lateral heel and right leg lower lateral. Resident #2 was interviewed on 1/15/19 at 10:30 AM and the resident stated he did not have any pressure ulcers when he came to the facility. Resident #2 stated that his right foot pressure ulcers were the result of using a boot to his right foot.	F 641	The Case Mix Director (CMD) performed MDS audits on Section M documentation for coding accuracy and supporting documentation for a 90-day look-back period. If discrepancies were identified, they were reviewed by both the MDS and Wound nurses and necessary corrections were made. Body Audits were conducted by the Unit Manager, DHS, Skin Integrity Coordinator and the Floor nurses, focus was on the residents on the certified unit. Any identified issues discovered during the audit were corrected by treatment evaluation, updating care plans, completing documentation per policy, treatment initiated along with the physician and family notification. Systems will be put into place to avoid recurrence of this deficient practice: 1.Education was provided on Thursday Jan. 24, 2019, by Regional Nurse Consultant regarding facility wound policies, practices, and documentation requirements, provided to the Wound nurse and Director of Health Services. 2.Director of Health Services and Clinical Competency Coordinator began education with the Nursing staff on Jan 24, 2019 to include documentation requirements, weekly body observation and wound policies and procedures. 3.Skin Integrity Coordinator (SIC) was assigned the following courses regarding wound care and wound management per online training resource Relias:	

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F 641	Continued From page 2 The MDS Coordinator #1 was interviewed on 1/15/19 at 2:46 PM regarding the skin assessment on the MDS. She stated that the Wound Care Nurse was responsible for assessing and filling in the skin assessment section. A telephone interview with the Wound Nurse was conducted on 1/15/19 at 4:13 PM. The Wound Nurse stated that she did not recall what she coded in the MDS dated 12/3/18. The MDS was read to the Wound Nurse that showed the resident was coded with 3 unstageable pressure ulcers from admission. She stated that it was an incorrect entry and the resident did not have 3 unstageable pressure ulcers on admission. The interim Director of Nursing was interviewed on 1/16/19 at 9:57 AM regarding her expectation on the MDS assessment. She stated that the MDS should reflect the correct entry for the resident.	F 641	a. Identification and Assessment □ RCL-SRC-0-AWC1A-V2 b. Assessment and Documentation □ PH-Lippincott_2654114 c. Unishield 2012 Wound Care Review □ RCL_P18434 d. MDS 3.0 Section M □ REL-PAC-0-US 3.0SECM19. 4.Upon admission, skin observations will be completed as part of the admission process by the admission nurse or assigned nurse. The Skin Integrity Coordinator (SIC) will review all new admission and readmission body audits for admissions that occur Sun-Thurs. and for Admission/Readmissions that occur Fri-Sat the week-end supervisor will review the body observation. 5.Skin Integrity Coordinator/Unit Managers/Weekend Managers will review the body audits weekly x 4 weeks that were completed from the week prior to ensure any identified areas are care planed, proper documentation is in place, treatment initiated, and MD and family were notified. Any concerns/ discrepancies will be addressed with the Director of Health Services and/or Unit Manager. 6.The Case Mix Director will review documentation of body observations when MDS is due to assure notes are present to support accurate MDS coding. Monitoring to assure effectiveness: The Director of Health Services, Case Mix Director, and/or assigned will analyze body observations completed upon	

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F 641	Continued From page 3	F 641	admission/readmission, Wound documentation, and coding and present findings to the QAPI meeting monthly until two consecutive months of compliance has been sustained. Responsibility: Administrator	
F 686 SS=D	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 observation, resident interview, staff interviews and record review the facility failed to prevent an avoidable pressure ulcer to resident's right lateral heel, anterior right heel, and right leg lower lateral that resulted in multiple unstageable pressure ulcers for 1 (Resident #2) of 3 residents reviewed for pressure ulcer. Findings included: Resident #2 was admitted in the facility on 11/26/18 with a diagnosis of closed fracture to	F 686	Affected resident resolution: Resident #2 "Skin re-assessments/observations were performed by the unit manager and assigned nurse on Resident #2. "Clinical Case Mix Director (CMD), Skin Integrity Nurse (SIC) and the Director of Health Services reviewed the documentation, coding and treatment plan and corrected any inaccuracies if needed at that time.	2/10/19

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F 686	Continued From page 4 right distal femur, metastatic adenocarcinoma and Diabetes. The resident underwent a surgery for retrograde nailing (fixation method for fractures) of distal femur from the hospital. The Minimum Data Set (MDS) dated 12/3/18 stated that the resident was cognitively intact, makes self-understood and had the ability to understand others. It stated in the assessment that the resident did not reject any care. It was also coded that the resident needed extensive assistance with bed mobility, transfer, dressing and personal hygiene. The admission skin assessment from 11/26/18 by Nurse #1 showed no blisters or wound from resident's right lateral heel, anterior right heel, and right leg lower lateral. A telephone interview with Nurse #1 on 1/15/19 at 3:17 PM was conducted and Nurse #1 stated that her documentation on admission notes reflected the overall skin assessment. She also stated that her initial marks on a body drawing in her admission notes would indicate presence of wounds or blisters if it were present at that time. If there were no marks on the admission notes, it only meant that there were no wounds or blisters. The initial Physical Therapist assessment notes on 11/27/18 did not indicate the presence of wound on the resident's right lateral heel, anterior right heel, and right leg lower lateral. There was a wound with dark area on lateral portion of upper shin identified in this assessment as written by Physical Therapist (PT). The PT was interviewed on 1/15/19 at 2 PM and she stated that there were no notes on her assessment for the presence of any wound to resident's right lateral heel, anterior right heel, and right leg lower	F 686	Identification of other residents who could be affected: The Case Mix Director (CMD) performed MDS audits on Section M documentation for coding accuracy and supporting documentation for a 90-day look-back period. If discrepancies were identified, they were reviewed by both the MDS and Wound nurses and necessary corrections were made. Body Audits were conducted by the Unit Manager, DHS, Skin Integrity Coordinator and the Floor nurses, focus was on the residents on the certified unit. Any identified issues discovered during the audit were corrected by treatment evaluation, updating care plans, completing documentation per policy, treatment initiated along with the physician and family notification. Systems will be put into place to avoid recurrence of this deficient practice: 1.Education was provided on Thursday Jan. 24, 2019, by Regional Nurse Consultant regarding facility wound policies, practices, and documentation requirements, provided to the Wound nurse and Director of Health Services. 2.Director of Health Services and Clinical Competency Coordinator began education with the Nursing staff on Jan 24, 2019 to include documentation requirements, weekly body observation and wound policies and procedures.	

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F 686	Continued From page 5 lateral, it meant she was not aware of any wound or blisters during her assessment. A History and Physical (H&P) notes on 11/26/18 written by the Doctor did not indicate any wounds or blisters. Another note written by the Physician Assistant (PA) on 11/27/18 indicated the skin was warm and dry, staples intact on the right lower leg. The PA was interviewed on 1/16/19 at 8:20 AM and the PA pointed out her assessment notes on 11/27/18 which showed no wounds was noted. The discharge summary from the hospital did not indicate any blisters or wounds on resident's right lateral heel, anterior right heel, and right leg lower lateral. There was a note written that resident was sent with an orthotic boot for his foot drop from the hospital. Resident #2 was interviewed on 1/15/19 at 1:33 PM and the resident stated that his right foot wounds was the result of using an orthotic boot to his right foot in the facility. The resident stated that the boot was placed by the Physical Therapist and stayed with him for several days including at night time in bed. Resident #2 stated that the boot was not removed for few days because he was not instructed to remove it and assumed it should stay all day and all night. He further stated that he complained to the Therapist and Nurses about the boot being uncomfortable. And when they removed it, there were several blisters on his right foot that were painful. In the Physical Therapy (PT) daily notes on 11/27/18 written by Physical Therapy Assistant (PTA) revealed that the resident had right orthotic boot in place. Another PT daily notes written on 11/29/18 indicated the resident was with right foot	F 686	3.Skin Integrity Coordinator (SIC) was assigned the following courses regarding wound care and wound management per online training resource Relias: a. Identification and Assessment □ RCL-SRC-0-AWC1A-V2 b. Assessment and Documentation □ PH-Lippincott_2654114 c. Unishield 2012 Wound Care Review □ RCL_P18434 d. MDS 3.0 Section M □ REL-PAC-0-US 3.0SECM19. 4.Upon admission, skin observations will be completed as part of the admission process by the admission nurse or assigned nurse. The Skin Integrity Coordinator (SIC) will review all new admission and readmission body audits for admissions that occur Sun-Thurs. and for Admission/Readmissions that occur Fri-Sat the week-end supervisor will review the body observation. 5.Skin Integrity Coordinator/Unit Managers/Weekend Managers will review the body audits weekly x 4 weeks that were completed from the week prior to ensure any identified areas are care planed, proper documentation is in place, treatment initiated, and MD and family were notified. Any concerns/ discrepancies will be addressed with the Director of Health Services and/or Unit Manager. 6.The Case Mix Director will review documentation of body observations when MDS is due to assure notes are present to support accurate MDS coding. Monitoring to assure effectiveness:	

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F 686	Continued From page 6 orthotic boot in place. An interview was conducted with the PTA on 1/15/19 at 4:45 PM regarding the use of the boot and the PTA stated that the resident was wearing the boot when she worked with the resident. She did not provide an answer who ordered and assisted the resident to put on the boot. An interview was conducted to Nurse #2 on 1/15/19 at 3:40 PM. Nurse #2 stated that she remembered Resident #2 was wearing the boot in the bed. She also stated that Resident #2 claimed his boots were bothering his heels and they removed it. She stated that when they removed the boot there were blisters on his right lower foot. On 1/15/19 at 1:23 PM, an interview was conducted with NA #4. The NA remembered the blue boot that the resident wore during his first days of admission. She also stated that she did not remember any wounds from the resident's right heel. A treatment observation was done on 1/15/19 at 10:30 AM with the Wound Care Nurse. The Resident's wound on the right heel was covered with black eschar. The old dressing removed was seen with moderate yellowish drainage. The right leg lower lateral wound was covered with yellow slough. It had some yellowish drainage from the old dressing that was removed. There was some redness noted on the right small toe. The wound consultation notes dated 12/3/18 indicated 4 pressure ulcers and 1 edema. On the right lateral leg, the area measured by length x width x depth (L x W x D) with 1.5 centimeters (cm) x 1.5 cm with an estimated depth of 0.3 cm	F 686	The Director of Health Services, Case Mix Director, and/or assigned will analyze body observations completed upon admission/readmission, Wound documentation, and coding and present findings to the QAPI meeting monthly until two consecutive months of compliance has been sustained. Responsibility: Administrator	

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F 686	Continued From page 7	F 686		

and clinically classified as Deep Tissue Pressure Injury (DTPI). On the anterior right heel area, it measured at 3 cm x 3 cm x 0.3 cm (estimated) and was clinically classified as DTPI. On the right heel lateral area, it was measured at 1 cm x 1 cm x 0.3 cm (estimated) and was clinically classified as DTPI. On the right leg lower lateral area, it was measured with 3.5 cm x 2.5 cm x 0.3 (estimated) and was clinically classified as unstageable. An on the right leg lower area, it was measured with 1 cm x 1 cm x 0.2 cm and was classified as edema.

The Wound Consultant was interviewed on 1/16/19 at 8:33 AM. She stated the facility referred the resident for wound consult and she assessed the resident on 12/3/18. She stated that there were 5 areas on her admission notes with 4 areas of unstageable pressure ulcer. On her interview she stated that she wrote in her wound consult that the pressure ulcers were admitted from the hospital, but she stated that she was not sure when it started. She stated that the orthotic boot caused the pressure as the resident had claimed. The Wound Consultant stated that there were 2 remaining unstageable pressure ulcer including 1 other wound still being treated on resident's right foot.

Review of the Physician's order notes revealed the treatment orders for the pressure ulcers were started on 12/3/18.

The PA progress notes on 12/4/18 indicated the patient complained of the current boot for his right foot and was causing blisters to top foot and heel. It was also written in the plan of care to continue the treatment with wound/team.

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F 686	Continued From page 8 An interview with the interim Director of Nursing (DON) on 1/16/19 at 12:15 PM and she stated that she expected her nurses to follow good nursing care to prevent avoidable pressure ulcers from developing.	F 686		