STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345458	A. BUILDING _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	2059 TORREDGE ROAD DURHAM, NC 27712

(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 000	INITIAL COMMENTS A complaint investigation survey was conducted from 10/13/20 through 10/16/20. Event ID N2MD11. 1 of the 1 complaint allegation was substanstiated resulting in deficiencies.	F 000		
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 observation, record review, staff interviews, Nurse practitioner interview and Wound Physician interview, the facility failed to prevent an avoidable pressure ulcer to the right mid inner forearm and right heel that resulted in hospitalization for sepsis for 1 of 3 sampled residents (Resident #1). The findings included: Resident #1 was admitted to the facility on 4/29/16. The resident diagnoses included dementia, diabetes and contractures.	F 686	Corrective Action for those residents found to have been affected by the deficient practice Resident #1 has been under the service of the wound care medical doctor since 9-1-2020. Responsible party aware. Care planned updated 9-1-2020 and on 10/16/2020. Staff involved immediately educated on the skin management program and change in condition with emphasis on weekly and daily skin integrity checks by the licensed nurse and CNA respectively.	11/16/20

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

Electronically Signed | 11/05/2020

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F 686	Continued From page 1 Review of quarterly Minimum Data Set (MDS) assessment dated 7/3/20 revealed Resident #1 was cognitively impaired and was fully dependent on staff to accomplish activities of daily living. Resident #1 had contractures to bilateral lower extremities, bilateral hands and right arm. Review of Resident #1 care plan dated 6/3/20 revealed Resident #1 was at risk for impaired skin related to impaired mobility and incontinence with a goal to remain free from skin breakdown. Interventions included: apply barrier cream to skin after each incontinent episode paying attention to bony prominences, keep bed linen clean, dry and free of wrinkles, meds/treatment per doctor's order, required pressure relieving mattress on bed and pressure reducing cushion in wheel chair, turn and reposition on rounds and as needed. Review of Resident # 1 progress note dated 8/31/20 revealed that Resident #1 had a new wound to right forearm and right hand. Review of Resident #1 medical records revealed head to toe weekly skin assessment dated 8/31/20 that indicated Resident # 1 skin was impaired. Further review of weekly skin assessment revealed no documentation of Resident # 1 skin condition for the week of 8/17/20 and 8/24/20. Review of Resident #1 medical record revealed pressure ulcer risk evaluation dated 10/13/20 that indicated Resident #1 was high risk for skin breakdown, the pressure ulcer risk evaluation prior to that was dated 8/28/19 and indicated Resident #1 was at mild risk for skin Breakdown.	F 686	Education completed on 11/16/2020. How the facility will identify other residents having the potential to be affected by the same deficient practice Braden scales and Body audits were completed on all residents and no other residents were identified to have been affected by the alleged deficient practice. Residents were assessed for skin integrity concerns. No other residents were identified to have been affected. Residents with contractures were assessed for skin integrity concerns. No other residents were identified to have been affected. Completed on 11/16/20. What measure will be put into place or systematic changes made to ensure that the deficient practice will not recur? Re-education was provided to nursing staff (nurses and nursing assistants) regarding how to conduct a head to toe body audit and skin observation Education provided to nursing staff on the skin management program. Wound care nurse/UM/designee will monitor skin management program for compliance. DON will have oversight of the skin management program. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained? Random audits of skin integrity assessment will be completed 3 times a week for 4 weeks, then 1 time a week for	

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F 686	Continued From page 2 Review of Resident #1 Occupational Therapy treatment encounter note dated 8/31/20 revealed Resident #1 had an odorous wound on the volar aspect of forearm. Review of specialty physician wound evaluation and management summary dated 9/1/20 revealed Resident #1 had a stage 4 pressure wound to the right arm. The wound size was (L x W x D) 3.0 x 2.5 x 1.0 cm with moderate serous exudate, 50 % necrotic tissue and 50% granulation tissue. The physician wound evaluation summary also revealed Resident #1 had a stage 2 pressure ulcer of the right heel that measured (L x W x D) 0.3 x 0.5 x 0.1 cm. Review of Hospital Admission History and Physical dated 9/18/20 revealed Resident #1 was seen at the Emergency Room for a chronic wound of the right inner arm. The doctor's assessment revealed: Presents with large stage IV pressure ulcer of flexor surface of right forearm in the setting of her chronic contracture. Also with hypernatremia, meets criteria for sepsis (leukocytosis and tachypnea). She received antibiotics (vancomycin/zosyn x1), intravenous fluids, and was admitted to General Medicine for further management. Resident #1 was observed on 10/13/20 at 2:00 PM lying in bed with eyes closed, had oxygen nasal cannula on and was nonverbal. The Wound Physician and Wound Care Nurse were doing wound care. Measurements of Resident #1 wounds by Wound Physician were: 1. Right mid inner forearm: 8 x 5 x 1.3, undermining at 12 o'clock, 70% necrosis and 30% granulation. 2. Right heel: 3.5 x 3.5, blackened.	F 686	thereafter Findings will be brought to the monthly quality assurance and performance improvement monthly x 3 months until substantial compliance is achieved.	

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Interview with Nursing Assistant #1 (NA #1) on 10/14/20 at 1:47 PM revealed she had cared for Resident #1 prior to discovery of pressure ulcer to right forearm. The interview further revealed NA#1 did not observe Resident #1 forearm skin when bathing and dressing her and therefore did not see the wound. The interview also revealed that no padding was used on Resident #1 right forearm.

Interview with NA #2 on 10/13/20 at 12:53 PM revealed Resident #1 right arm skin was not observed during bathing and dressing and the wound was missed. NA #2 stated she was the one who had bathed and dressed Resident #1 and did not see the wound. She also stated she was informed of the wound by one of the therapists and would have informed the nurse if she had seen the wound. She further stated she was not instructed by anyone to use a pillow or pad the arm.

Interview with Occupational Therapist (OT) on 10/13/20 at 12:23 PM revealed she was the one who had found Resident #1 right forearm wound. OT stated Resident #1 had had upper body contractures for almost a year with a lot of spasticity. The interview revealed OT started working with Resident #1 on 08/24/20 for bilateral thumb range of motion. She stated that as soon as she moved Resident #1 right arm, she noticed a foul smell and her glove became wet, she pulled the resident right sleeve up and found a stage 4 wound to the mid inner forearm. She stated she informed the nurse unit manager and OT supervisor about the wound. She also stated the pressure ulcer might have been prevented if the skin was assessed everyday and arm repositioned.

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Interview with Nurse #1 on 10/14/20 at 1:12 PM revealed she had cared for Resident #1 prior to the discovery of Resident #1 right forearm wound. Nurse #1 stated nurses were to complete a head to toe assessment of resident skin and document it on a weekly basis. She stated she had examined Resident #1 skin and did not see any skin impairment but may have forgotten to document it.
Interview with Nurse #2 on 10/14/20 at 9:02 AM revealed he was aware of requirement for residents' weekly skin assessment and documentation. He stated nurses were to assess and document resident weekly skin assessment when the reminder came up on the computer. He also stated Nursing assistants would notify nurses if they noticed any new skin impairment while bathing and dressing resident. He further stated nobody saw Resident #1 wound until OT found it.

Interview with Nurse #3 on 10/14/20 at 12:12 PM revealed she was the Unit Manager. The interview revealed she was notified of Resident #1 right forearm wound by OT on 08/31/20. The Unit manager stated nurses were to complete a head to toe assessment of resident skin weekly and document their findings even if the resident did not have any skin breakdown. This interview also revealed that Resident #1 head to toe skin evaluation was not documented for the week of 8/17/20 and 8/24/20. The Unit manager stated she could not locate the missing documentation since she was not working at the facility at that time.

Interview with Nurse Practitioner (NP) on 10/14/20 at 9:30 AM revealed she was informed

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F 686	Continued From page 5	F 686		

of Resident #1 right forearm wound by the Unit Manager. She stated she found an unstageable silver dollar size wound with yellow slough on Resident #1 right forearm. The interview also revealed she asked staff to pad Resident #1 right arm and to consult Wound Physician to see Resident #1.

Interview with Wound Physician on 10/13/20 at 1:22 PM revealed he was consulted by the Facility to assess Resident #1 wounds. The Wound Physician stated Resident #1 had severe contractures, was elderly and thin. He stated it was possible for Resident #1 wound to present as a stage 4 pressure ulcer because of the resident comorbidities that included diabetes and contractures. He stated padding might have helped to relieve pressure.

An interview was conducted with the Director of Nursing (DON) on 10/13/20 at 12:15 PM. She stated nurses were to complete a pressure ulcer risk evaluation for all residents quarterly and more often if the resident condition warranted it. She also stated pressure ulcers could be minimized, during care if noticed. She further stated it was unfortunate that Resident #1 developed a pressure ulcer in a non-bony prominence area. A second Interview was conducted with the DON on 10/16/20 at 1:20 PM. She stated nurses were to complete resident weekly head to toe assessment and document it as per Facility Policy and Procedure for Pressure Ulcer and Skin Care Management.