

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345202</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/31/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CAPITAL NURSING AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3000 HOLSTON LANE</b> <b>RALEIGH, NC 27610</b>
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F 000	INITIAL COMMENTS  An unannounced complaint investigation was conducted on 3/30/21 through 3/31/21. 1 of 7 complaint allegations was substantiated. Event ID# H5PQ11.	F 000		
F 686 SS=E	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 staff and physician interviews and record review the facility failed to assess and initiate pressure ulcer care on a resident with a newly identified wound for five days for 1 of 1 resident reviewed for pressure ulcer care. (Resident #1)  Findings included:  Resident #1 was admitted to the facility on 2/24/21.  A review of Resident #1 ' s minimum data set assessment dated 3/3/21 revealed he was	F 686	For the affected resident, Resident #1, the resident's skin tear was noted on 3/3/2021, and progressed to a pressure ulcer. Care was initiated on 3/8/2021 for this resident, and he discharged from the facility on 3/19/2021.  1. Corrective action for residents with the potential to be affected by the alleged deficient practice.  Beginning on 3/31/2021 the Director of Nurses, and staff nurses audited all resident's skin to ensure there were no	4/6/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE <b>04/20/2021</b>
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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>assessed as moderately cognitively impaired. He had no behaviors. Resident #1 required extensive assistance with bed mobility and eating. He was assessed to be totally dependent on staff for transfers, dressing, toilet use, and personal hygiene. He was always incontinent of bowel and bladder and had a condom catheter. Resident #1 ' s active diagnoses included stroke, atrial fibrillation, coronary artery disease, heart failure, hypertension, diabetes, and hemiplegia or hemiparesis. He was assessed to have no pressure ulcers and had a pressure reducing device for his bed.</p> <p>A review of Resident #1 ' s care plan dated 2/24/21 revealed he was care planned to be at risk for pressure ulcer development. The interventions included to apply moisture barrier with each brief change and as needed, assist with position changes throughout the shift in order to minimize pressure and to increase comfort, reposition during personal care, bathing, incontinence care, when assisting with bed mobility, and as requested and tolerated, encourage to shift weight frequently when sitting up in chair, float heels on pillows when in bed, linen cradle to foot of bed, observe skin for redness and open areas upon return from dialysis, inform nurse if any areas are noted, pressure reducing mattress on bed, provide incontinence care as needed, report to nurse immediately if redness, open areas, irritation to skin is noted, use maxislide and drawsheet to aid with positioning in bed in order to reduce friction and shearing, and perform weekly full body skin assessments.</p> <p>A review of Resident #1 ' s discharge summary from the hospital revealed he did not have a</p>	F 686	<p>new skin integrity alterations identified. This was accomplished by completing total body skin assessments for all residents by the Director of Nurses and staff nurses. 85 of 86 residents had no newly identified skin integrity alterations identified. During the 100% audit, one resident was noted to have a new skin tear. Treatment was started, family/MD were notified, and resident was care planned for skin tear. Beginning on 4/1/2021 the Director of Nurses, staff nurse and Minimum Data Set Coordinator audited all residents to assure the physician was notified if new orders were required, all needed orders were in place, documentation of skin integrity alterations were completed and resident care plans were updated if needed. This process was completed by 4/2/2021.</p> <p>2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:</p> <p>On 3/31/2021, the Director of Nurses began an in-service education to all full time, part time, and as needed nurses and CNA's. Topics included:</p> <ul style="list-style-type: none"> <li>• Requirements for wound/skin integrity documentation and the wound process.</li> <li>• How pressure ulcers develop, how to prevent pressure ulcers and what to do when a new skin area is noted.</li> <li>• How to apply these principles to their daily practice.</li> </ul> <p>This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be</p>		

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F 686	<p>Continued From page 2</p> <p>pressure ulcer to his sacrum upon admission to the facility.</p> <p>A review of a weekly skin check dated 2/24/21 revealed Resident #1 did not have any skin issues.</p> <p>A review of a weekly skin check dated 3/3/21 revealed Nurse #1 noted Resident #1 had an open area between upper buttocks upon his skin check. The wound care nurse was notified.</p> <p>There was no documentation of a wound assessment or treatment from 3/3/21 through 3/8/21.</p> <p>A review of a weekly pressure ulcer review dated 3/8/21 revealed Resident #1 was noted to have a wound to sacrum by the nurse aide. The wound care nurse was then notified, and treatment was initiated as a new onset pressure ulcer stage II which measured 3.0 centimeters long by 2.0 centimeters wide with no depth and 100% granulation tissue with no odors. The responsible party was notified.</p> <p>A review of Resident #1 ' s orders dated 3/8/21 revealed he was ordered to have the sacral wound cleansed with wound cleanser, pat dry, skin prep skin and apply hydrocolloid dressing every day shift every 5 days for wound as needed for wound soilage. This order was discontinued on 3/12/21. On 3/12/21 he was ordered to have the sacral wound cleansed with wound cleanser, pat dry, skin prep skin, apply xeroform dressing and cover with an island dressing every day shift every 2 days for wound as needed for wound soilage. He was discharged on 3/19/21.</p>	F 686	<p>reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency nurses and CNA's who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training by April 6, 2021 will not be allowed to work until training has been completed.</p> <p>3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.</p> <p>The Director of Nursing, and/or her designee will utilize the QA tool for Pressure Ulcer Prevention and Wound/Skin Assessment Process. The Director of Nurses, and/or her designee will monitor three residents with new wounds or skin integrity alterations weekly for 2 weeks, then monthly for 3 months, for wound assessment UDA completion and implementation of pressure ulcer prevention strategies if indicated. 3 residents with newly identified pressure wounds or skin alterations will be monitored for timely wound assessment completion and initiation of pressure relieving interventions and treatments weekly x2 weeks then monthly for three months. This tool will be completed as stated above or until such time that the QA Committee determines the need to change the frequency of the audit (when it has been determined that sustained compliance has been achieved).</p>		

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F 686	<p>Continued From page 3</p> <p>A review of a wound clinic visit dated 3/12/21 revealed Resident #1 ' s wound was seen by the wound clinic at the request of the physician ' s referral. There was no exudate noted and no pain was associated with the wound. The wound measured 5.0 centimeters long by 3.0 centimeters wide by 0.2 centimeters deep. No exudate with 5% slough and 10% granulation tissue.</p> <p>A review of the treatment record for March 2021 revealed Resident #1 received his treatments as ordered.</p> <p>A review of a wound clinic note dated 3/19/21 revealed Resident #1 was unable to be seen as he had been discharged home.</p> <p>Resident #1 was discharged home from the facility on 3/19/21.</p> <p>The wound care nurse was on medical leave and was unavailable to be interviewed during the survey.</p> <p>During an interview on 3/30/21 at 1:48 PM Nurse #1 stated she performed the skin check on Resident #1 on 3/3/21. She stated it appeared to be a skin tear to his sacral area that she would estimate to be about 2 centimeters long by 2 centimeters wide. She stated she documented this in the skin assessment and notified the wound care nurse. She concluded she did not know if the wound care nurse followed up with that referral as there was no documentation. She further stated a few days to a week later Nurse Aide #1 came to her at the cart and said there was a wound on Resident #1 without a dressing and asked if a dressing needed to be put on the</p>	F 686	<p>Identified area of concern are to be immediately addressed. The DON will present the results to the QA Committee. The monthly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Dietary Manager, Maintenance Director, Medical Director, and Consulting Pharmacist.</p> <p>Date of Compliance: 4/6/2021</p>		

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F 686	<p>Continued From page 4</p> <p>wound as she was in the middle of providing incontinent care. Nurse #1 stated as this was the same wound as the one, she referred on 3/3/21, she went immediately to the wound care nurse and asked about the wound and what the order was. The wound care nurse told her there was no order and did not indicate if she had or had not assessed him as a result of the nurses ' first referral. She concluded the wound care nurse then initiated wound care and an order was put in place. The nurse did not visualize the wound again and did not know how it had progressed, and she did not know if it had been assessed on 3/3/21 or why it had not been assessed and treated until the second time it was brought to her by Nurse Aide #1.</p> <p>During an interview on 3/30/21 at 2:12 PM the Director of Nursing stated Resident #1 did not enter with a pressure ulcer from the hospital. His initial skin assessment 2/24/21 did not identify any skin concerns. On 3/3/21 during his weekly skin assessments, Nurse #1 identified a skin concern to his sacral area and notified the wound care nurse. The wound care nurse should have assessed and documented her assessment and plan following this referral and she did not. Then on 3/8/21 Nurse Aide #1 notified the wound care nurse again that Resident #1 had an undressed wound to his sacrum. This time the wound care nurse did perform an assessment and documented the assessment on the chart. The wound was identified at this point as a stage II pressure ulcer which was 3 centimeters long by 2 centimeters wide with granulation tissue. The wound care nurse got a physician ' s order and treatment was started. She concluded the wound should have had documentation and treatment for the five days of 3/3/21 through 3/7/21.</p>	F 686			

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

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F 686	Continued From page 5  During an interview on 3/30/21 at 2:28 PM Physician #1 stated the wound care nurse should have documented an assessment after being notified of the wound on 3/3/21 and notified him of the presence of a wound on Resident #1 at that time. He concluded Resident #1 did not sustain any deterioration in his condition as a result of the five-day delay in initiating wound care.  During an interview on 3/30/21 at 3:15 PM Nurse Aide #1 stated she remembered on 3/8/21 she was working with Resident #1 for the first time. She stated it was strange because she was providing incontinent care and saw a wound on his sacrum that was concerning enough that she felt it should have had a dressing on it so she asked the nurse if he needed his dressing to be reapplied before she completed her incontinent care. She stated the nurse then got another staff member and they assessed the wound and implemented treatments as it did not appear there were any orders for the wound. She concluded she was agency staff and was not sure of who came to assess the resident, but she was confident there had not been a dressing on the resident prior to her bringing her concern to the nurse.	F 686			