STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345216	A. BUILDING _____ B. WING _____	C 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTFIELD REHABILITATION AND HEALTH CENTER	**3100 TRAMWAY ROAD SANFORD, NC 27330**

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 08/20/24 through 08/23/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #SP0Y11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 08/20/24 through 08/23/24. Event ID# SP0Y11. The following intake was investigated NC0020541. 1 of the 1 complaint allegation did not result in deficiency.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F 580		9/30/24

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

Electronically Signed | 09/26/2024

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F 580	Continued From page 1 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, and staff and Medical Director (MD) interviews, the facility failed to notify the MD when a stage three pressure ulcer was identified for 1 of 1 resident reviewed for pressure ulcer (Resident #71). Findings Included: Resident #71 was admitted to the facility on 08/02/24 for fracture of right femur with a plan for discharge home after rehabilitation. Resident #71 was discharged from the hospital after surgery to	F 580	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	

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F 580	Continued From page 2 repair a right femur fracture. Review of the Wound Care Nurse's assessment on admission on 08/02/24 revealed she noted redness to sacral area. On 08/23/24 at 12:31 pm a telephone interview with Nurse #1 revealed on 08/13/24 she was called to the resident's room by the (Nurse Aide) NA providing care to Resident #71. She reported the sacral pressure ulcer appeared to have slough, she measured it and left a message for the Wound Care Nurse to further assess. Wound Care Nurse's note dated 08/14/24 revealed that a sacral pressure ulcer was noted by the 11:00 PM to 7:00 AM shift nurse. This nurse reported that the resident had a stage 3 sacral ulcer. Description of the wound was 70% slough and 30% granulation tissue, unstageable and measured 2.7 cm (cm) in length and 2.5 cm in width. There was no documentation the Medical Director was notified. On 08/23/24 at 09:23 am an interview with Medical Director (MD) revealed that Resident #71 was admitted on 08/02/24 and he was first informed of the stage three pressure ulcer on 08/16/24. The MD stated the delay in his notification was acceptable if another clinician had been notified.	F 580	Identification of potentially affected residents and corrective actions taken: On 9/25/2024 the designated clinical team audited all new or worsening reported change in condition for the month of September to ensure that the Physician and R.P. had timely notification of the change in condition: Results: No issues were identified with that audit. Education On 09/25/2024 the DON/RN Supervisor began education of all full time, part time, as needed licensed nurses and agency nurses on the following topics: " Timely notification of the physician of change in condition. " Notification of the R.P. of a change in condition. " Change in condition process and identification of change in condition. The DON will ensure that any of the above identified staff who does not complete the in-service training by 09/30/24 will not be allowed to work until the training is completed. This in-service was incorporated into the new employee facility orientation for the above identified staff. Quality Assurance Plan: The DON will monitor this utilizing the Change in Condition and Notification Quality Assurance Tool. The monitoring will include review of change in condition Monday -Friday during the Daily Clinical meeting for compliance with the process weekly x 2 and monthly x 3 or until resolved by the Quality Assurance (QA)	

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F 580	Continued From page 3	F 580	Committee. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action was initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, S, Therapy, HIM, and Dietary Manager. Date of compliance: 09/30 /2024	
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 record review, observations, and staff and Medical Director (MD) interviews, the facility failed to do a weekly skin assessment which resulted in the delay of identification of a stage three pressure ulcer for 1 of 1 resident reviewed for pressure ulcer (Resident #71).	F 686	Past noncompliance: no plan of correction required.	

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F 686	Continued From page 4	F 686		

The findings included:

Resident #71 was admitted to the facility on 08/02/24 for fracture of right femur with a plan for discharge home after rehabilitation. Resident #71 was discharged from the hospital after surgery to repair a right femur fracture.

Review of the Wound Care Nurse's assessment on admission on 08/02/24 revealed she noted redness to sacral area.

Further review of records revealed that on 08/02/24 a verbal order for zinc oxide external ointment 20% (topical), apply to sacrum topically two times a day was initiated and to do weekly skin checks.

A care plan dated 08/05/24 revealed interventions of assistance with incontinence care and bed mobility to reduce the risk of pressure ulcer development.

The admission Minimum Data Set (MDS) dated 08/09/24 revealed that Resident #71 was moderately cognitively impaired. Resident #71 was coded to have no pressure ulcer and was incontinent of bladder with substantial /maximal assistance for shower/bathing and for lower body dressing and was dependent on staff for toileting.

There was no documentation of a weekly skin assessment in Resident #71's medical record.

On 08/22/24 at 10:57 am, an interview with the Wound Care Nurse revealed that she was responsible for the completion of the admission skin assessment for Resident #71. Nurse stated that the sacral skin redness was blanchable and

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F 686	Continued From page 5	F 686		

didn't indicate any pressure ulcer on admission. The Wound Care Nurse reported she put the order in place for the zinc oxide twice a day and weekly skin checks. The Wound Care Nurse reported that the nurses were responsible for the weekly skin checks. The interview further revealed that the weekly skin check scheduled on 08/09/24 was not done.

On 08/23/24 at 12:31 pm a telephone interview with Nurse #1 revealed on 08/13/24 she was called to the resident's room by the (Nurse Aide) NA providing care to Resident #71. She reported the sacral pressure ulcer appeared to have slough, she measured it and left a message for the Wound Care Nurse to further assess.

Wound Care Nurse's note dated 08/14/24 revealed that a sacral pressure ulcer was noted by the 11:00 PM to 7:00 AM shift nurse. This nurse reported that the resident had a stage 3 sacral ulcer. Description of the wound was 70% slough and 30% granulation tissue, unstageable and measured 2.7 cm (centimeters) in length and 2.5 cm in width.

Review of records revealed that Resident # 71 was seen by Wound Care Doctor on 08/21/24 for a wound on sacrum, left buttock. The Wound Care Doctor documented the wound was unstageable (due to necrosis), had moderate serous exudate and measured 3.5 cm (length) x 3.5 cm (width) and no measurable depth. Further review of records revealed treatment for the necrosis (the death of most or all the cells in a tissue) required surgical excisional debridement (the removal of damaged tissue from a wound). The Wound Care Doctor's orders for treatment plan was for calcium alginate with silver (absorbs

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F 686	Continued From page 6	F 686		

bacteria and fluid from the wound) to be applied once daily for 30 days. Santyl (removes dead tissue from wound) apply once daily for 30 days. May use medical grade honey if unable to use Santyl. Cover with a gauze island with a border. Apply once daily for 30 days.

On 08/22/24 at 9:01 am an observation of wound care completed by Wound Care Nurse revealed treatment of sacral wound with Santyl, calcium alginate with silver, and silicone bordered dressing daily. Resident #71 was observed on an air mattress and required assistance with turning. Resident #71 was lying on her left side while wound care was being completed. Resident #71 expressed discomfort prior to treatment but was medicated by the assigned nurse prior to initiation of treatment. The wound bed was clean, and there was no drainage and no odor.

Interview with Nurse Aide (NA) #1 on 08/22/24 at 10:22 am revealed that Resident #71 was incontinent and required assistance with turning. The interview further revealed Resident #71 gets a shower twice a week and any skin concerns were addressed with the nurse. NA #1 denied that resident was refusing showers and no abnormal skin issues reported.

On 08/22/24 at 11:30 am, an interview with MDS Nurse revealed skin assessments were completed by the unit nurse but if the unit was busy, this was completed by the Wound Care Nurse or the support nurse. During the interview the MDS Nurse reported that she was unsure of any standardized risk assessment tool used on admission.

On 08/22/24 at 03:25 pm, an interview with

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F 686	Continued From page 7	F 686		

Dietitian (RD) revealed that her initial assessment for Resident #71 was completed on 08/13/2024 and all the resident had was a surgical wound. The interview further revealed that she did not visually see the resident but was told that resident completed 0-75% of meals, and nothing further needed to be done as the resident was already on Pro-stat. Mighty Shake (changed to Ensure due to resident preference) ordered as soon as wound was noticed to assist with nutritional intake. The Dietitian revealed that the process for reporting of wound was via email by the Wound Care Nurse.

Interview of the Support Nurse on 08/22/24 at 03:45 pm revealed that she was assigned to the care of Resident #71 on admission. The Support Nurse reported that the expectation was that the nurse assigned to the resident would complete the skin assessment if the Wound Care Nurse was not around. The Support Nurse revealed Resident # 71's skin assessment was completed by the Wound Care Nurse on 08/02/24 and the order for skin checks were flagged automatically in the electronic chart.

On 08/23/24 at 09:23 am an interview with Medical Director (MD) revealed that Resident #71 was admitted on 08/02/24 and he was first informed of the stage three pressure ulcer on 08/16/24. The MD stated the delay in his notification was acceptable if another clinician had been notified.

Interview with Nurse Consultant on 08/23/24 at 11:31am revealed that it was possible for the wound to occur given the appropriate circumstances as Resident #71 fell at home prior to admission, and this may have affected her risk

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F 686	Continued From page 8	F 686		

for skin breakdown.

On 08/23/24 at 11:31 am an interview with the Administrator revealed a plan was set in place after Resident # 71's wound was found. She reported that these steps would be identifying the factors, refer to dietitian, refer to wound care physician, refer to PT for cushions and the need for air mattress. The interview further revealed it was not the expectation for the skin to go from blanchable to stage 3 ulcer.

The facility provided the following corrective action plan with a completion date of 08/19/24.

1. Corrective action for resident (s) affected by the alleged deficient practice.
-Head to toe assessment was completed on the affected resident, MD (Medical Director), RD (Registered Dietitian) and Family updated. New orders were initiated for wound.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.
-On 08/16/2024 head to toe skin assessments were completed on all current residents by the assigned nurse. This was completed on 08/16/2024. The results included: There were no new skin issues that were identified.

3. Measures/Systemic changes to prevent reoccurrence of deficient practice: Education (change of condition, pressure ulcer and treatment of pressure ulcer).
-On 08/16/2024 the Staff Development Coordinator (SDC) initiated in-service of all licensed nurses and Certified Nurse Assistants (CNA), including agency on change of condition,

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F 686	Continued From page 9	F 686		

pressure ulcer assessment and treatment of pressure ulcers.
-The Director of Nursing (DON) will ensure that any of the above identified staff who do not complete the in-service training by 8/19/24 will not be allowed to work until the training is completed.

4. 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.
-The DON/designee will monitor the skin assessment process weekly for 2 weeks and monthly for 3 months for compliance with the skin/wound process. Reports will be presented to the weekly quality assurance (QA) committee by the wound nurse or DON to ensure corrective action initiated as appropriate. Compliance will be monitored, and ongoing auditing program reviewed at the monthly QA Meeting. The QA Meeting is attended by the Administrator, DON, MDS Coordinator, Wound Nurse, Therapy, Health Information Manager and the Dietary Manager.

The corrective action plan was completed on 08/20/2024.

Onsite validation was completed on 08/23/24 through staff interviews and record review. Staff were interviewed on training, reporting and timing of reporting. A review of the audits of the residents' notes for skin checks for all residents was noted to be completed on 08/16/24. The review of the audit tools that the facility provided were noted to be completed 08/15/24 to 08/19/2024. The facility's corrective action plan completion date of 08/20/2024 was validated.