STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
✓	345513	A. BUILDING _____ B. WING _____	C 11/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to follow or seek clarification to recommendations made during a podiatry consult for 1 of 3 sampled residents (Resident #1) which could have contributed to reinfection and repeated surgery. Findings include: Resident #1 was admitted to the facility on 05/01/08. The resident's documented diagnoses included dementia, deep venous thrombosis, and anemia. The resident's 09/26/11 Quarterly Minimum Data Set (MDS) documented she had severe cognitive impairment, and did not exhibit rejection of care. A 09/28/11 Nurse's Note documented Resident #1 had blood coming from around her left great toenail. A 10/10/11 Nurse's Note documented Resident #1's primary physician recommended the resident be seen by a podiatrist because of tingling and pain in the left foot. A 10/11/11 podiatry consult documented "possible ingrown nails both great toes". Diagnoses included onychomycosis (fungal infection), paronychia (skin infection) of the toe, and ingrown	F 281	Tower Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Tower Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Tower Nursing and Rehabilitation Center has the right to refute any of the deficiencies through Informal Dispute Resolution, formal appeal procedure, and/or any other Administrative or legal proceeding.	11/30/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	11/30/11

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

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F 281	Continued From page 1 nail. The consult documented, "The location of onychomycosis is: bilaterally on the hallux (great toe) toenail, second toenail, third toenail, fourth toenail, and fifth toenail. The onychomycosis is described as dull, squeezing, throbbing, tingling, and discolored. The severity of the symptoms associated with the onychomycosis is described as severe. The symptoms associated with the onychomycosis are : intermittent and worsening." The consult also documented surgical excision of the nail matrix. A 10/11/11 physician order began ten minute soaks twice a day for Resident #1's bilateral feet. The resident's feet were to be soaked in warm water with Epson salts, dried, and to have neosporin (antibiotic cream) applied and then to have the left toe covered with a band-aid or cotton gauze for one week. Record review revealed the soaks and application of antibiotic cream were completed for Resident #1 between 11/12/11 and 11/18/11. A 10/20/11 podiatry consult documented, "The ingrown toenail is located on the left, lateral border, medial border hallux. The ingrown toenail is described as painful, drainage and sharp. The symptoms associated to the ingrown toenail are worsening." Course of treatment was described as, "incomplete response to treatment, not progressing as expected." The summary documented, "Soak both feet in lukewarm salt water approximately 4 tablespoons Epson salts and one quarter water, twice a day. Follow with Neosporin and gauze to first toenails, bilateral until healed."	F 281	Resident # 1 continues to receive current treatments as ordered by her consulting Physician as of initial correction to orders on 11/08/11. All Residents with appointments for the past 30 days were reviewed by Administrative Nurses to ensure orders received as a result of consultations or appointments had been written and implemented. Concerns and clarification needs if identified were addressed at the time of the review by the Administrative Nurse to include Physician notification as indicated. Inservice of All Nurses to include Treatment Nurses was initiated on 11-18-11 by the Director of Nursing related to clarifying and following Physician Orders to include those received as a result of consultations and appointments and ensuring information received after appointments is reviewed for orders. The in-servicing was completed on 11/30/11 by the DON.	11/30/11

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F 281	Continued From page 2 Review of the October and November 2011 Medication Administration Records (MARs) and Treatment Administration Record (TARs) revealed Resident #1 did not receive foot soaks or the application of neosporin cream from 10/20/11 until 11/10/11. A 11/08/11 physician order initiated treatment for Resident #1's left great toe which consisted of cleaning with wound cleanser, followed by the application of Bactroban, to be covered with a dressing daily until healed. The order also started the resident on Keflex (oral antibiotic) 500 milligrams (mg) twice daily x 7 days. A 11/10/11 physician order changed the resident's oral antibiotic from Keflex to Augmentin 875 mg twice daily x 7 days. A 11/10/11 podiatry consult documented, "Findings specific to the right toenails: medial border, lateral border, hallux, healing from nail surgery, minimal erythema. Findings specific to the left toenails: medial border, lateral border, hallux, subungual hematoma, hypertrophic nail bed, paronychia infection, engorged with blood, needs to drain....Procedure : debride devitalized tissue, exsanguinate blood by pushing on the skin to allow for drainage....Summary: soak both feet in lukewarm salt water approximately 4 tablespoons Epson salts and one quarter water, twice a day. Follow with Neosporin and gauze to first toenails, bilateral until healed, Augmentin one week." On 11/18/11 between 11:55 AM and 12:12 PM the Treatment Nurse soaked Resident #1's feet in warm water with Epson salts for ten minutes,	F 281	In-servicing of Transporters was completed on 11/18/11 by the Director of Nursing related to ensuring documentation returned with a Resident is delivered directly to the Nurse or Nurse Supervisor. The in-servicing included instructing the transporters to inquire regarding documentation from the office or clinic when none was provided. Residents with appointments and consultations will continue to be reviewed in correlation with the QI Transportation Log and Physician orders as indicated after the appointment / consultation to ensure any instructions or orders received are implemented three times a week for four weeks then weekly for two weeks then monthly for a minimum of two months by an Administrative Nurse. A QI Tool will be utilized for the review.	

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F 281	Continued From page 3 dried the resident's feet, and applied neosporin and a dressing to the bilateral great toes. There was dried blood in the corners of the resident's right great toenail, and the resident's left great toe was slightly swollen and light purple in color. At 12:42 PM on 11/18/11 the Administrator reported the podiatry service following Resident #1 would be unable to converse via phone because of their busy schedule. At 1:02 PM on 11/18/11 Resident #1's primary physician stated the podiatrist must have thought there could be some complications after performing surgery to remove the resident's ingrown toenails, therefore ordering foot soaks followed by the application of an antibiotic cream. However, she commented surgical procedures were supposed to be sterile so use of an antibiotic following the procedures was not a necessity. She reported Resident #1 was a younger woman in the nursing home population who should have been able to fight off an infection. However, according to the primary physician, if the podiatrist thought an antibiotic cream was necessary and the cream was not applied, then after three or four days there could be a risk of re-infection. At 1:27 PM on 11/18/11 the Administrator stated the transporter, social worker, or hall nurse was supposed to place a copy of consultation reports under her door or the Director of Nursing's (DON's) door. However, the Administrator reported a copy of the 10/20/11 podiatry consult was not sent back to the nursing home with the resident. Therefore, the facility was unaware the foot soaks and application of antibiotic cream	F 281	The QI tools will be reviewed by the Quality Improvement Nurse with follow up as deemed necessary for any identified concerns. Findings will be compiled and forwarded to the facility Quality Improvement Executive Committee monthly for review and for the identification of trends, development of action plans as indicated, and to determine the need and / or frequency of continuing QI monitoring.	

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F 281	Continued From page 4 were supposed to continue for Resident #1. At 1:42 PM on 11/18/11 the DON stated she was not aware of any type of log/audit system which would make the facility aware when a consultant physician failed to send a copy of the consultation report back to the nursing home with the resident. At 1:55 PM on 11/18/11 the Treatment Nurse reported she was gone for the day when Resident #1 returned from the podiatrist on 10/20/11. However, the next day she stated she asked the hall nurse if Resident #1 returned from her 10/20/11 podiatry appointment with any new orders. She commented the hall nurse looked in Resident #1's chart, and reported no new orders were written. According to the Treatment Nurse, she did not question the hall nurse's report because she thought Resident #1's toes/feet were healing nicely. The Treatment Nurse reported she did not know who was responsible for making sure copies of consultation reports accompanied residents when they returned to the nursing home following their appointments.	F 281		