

SEP 14 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345172	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/24/2012
NAME OF PROVIDER OR SUPPLIER TRIAD CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 707 NORTH ELM STREET HIGH POINT, NC 27262		
(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 314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and medical record review the facility failed to: 1. provide a dressing to a lower extremity wound with deep tissue injury and 2. keep the pressure of the bed off the foot for one (1) of four (4) sampled residents. Resident #2.</p> <p>The findings were:</p> <p>Resident #2 was admitted to the facility on 9/6/10 with diagnoses of Diabetes Mellitus Peripheral Vascular Disease, history of Lower Extremity cellulitis, Left great toe amputation, and Chronic Obstructive Pulmonary Disease. Review of the Minimum Data Set dated 7/18/12 revealed Resident #2 required total assistance with bed mobility. Review of the careplan dated 7/18/12 revealed a problem of skin integrity with approaches to provide treatments as ordered, and positioning devices as needed.</p> <p>Review of the August 2012 monthly orders revealed the left foot was to be cleansed with</p>	F 314	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Triad Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>F314</p> <p>Resident #2's wound dressing was replaced on 8/23/12 at 2:30 PM by licensed nurse #1 and administrative nurse #2. Resident #2 continues treatment and elevation to the left heel per physician's order.</p> <p>All residents with physician orders for wound dressings and to elevate heels were assessed on 8/24/12 by the administrative nurses to ensure that wound dressings</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Alyce Stepping

TITLE

Administrator

(X6) DATE

9/12/12

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.

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

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FORM APPROVED
OMB NO. 0938-0391

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F 314	Continued From page 1 Microklenz. After cleaning, use a skin prep to the left toes and heel, and Santyl to the back of the heel. Cover with dry dressing. Change every day or as needed. Review of the Nurse Practitioner 's wound note dated 8/15/12 revealed a new area on the left heel that was described as a full thickness and deep tissue wound. (Several layers of visible skin are damaged as well as unseen skin that is damaged.) Review of the physician 's orders dated 8/16/12 revealed the Skillcare boots were discontinued and the left foot was to be elevated on a pillow. A review was conducted of the results dated 8/20/12, of a test to measure the blood flow in the left leg and foot. These test results revealed poor to minimal blood flow through the main arteries from the groin down the left leg. Observations on 8/23/12 at 11:10 AM revealed Resident #2 was lying on his back with both heels directly on the bed surface. Observations on 8/23/12 at 11:28 AM revealed Resident #2 had a Kerlix wrap dressing that was taped on one side of the left heel. The smaller gauze dressings were off, and the covering gauze dressing was off with the heel wound exposed. The date on the dressing was 8/23/12. The heel area was observed to have eschar (brown, thick-like scab that has underlying tissue injury) with the surrounding wound area that had the first layers of skin removed. During this observation, the aide was providing a bed bath. After the aide removed the topsheet, the left leg and heel were observed directly on the bed. The aide noticed the dressing was not covering the wound on the left heel and removed the loose gauze dressings.	F 314	were in place and secure. Residents with orders to elevate heels were assessed to ensure heels were elevated. Licensed nurse #1 was re-educated by Staff Development Coordinator regarding infection control with wound care, dressing changes policies, appropriate and timely follow up to reported concerns and the elevation of heels on 9/7/12. Nursing assistant #1 was re-educated by Staff Develop Coordinator regarding infection control with wound care, the elevation of heels while in bed and reporting of changes or concerns to the charge nurse with appropriate follow up procedures with the Unit or Nursing Management on 9/7/12. Licensed Nurses and Certified Nursing Assistants will be re-educated by Staff Development Coordinator regarding infection control with wound care, wound care policies including elevation of heels, dressing changes, reporting and addressing changes and concerns to the charge nurse in a timely manner and appropriate follow up with nursing management by 9/14/12.		

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F 314	<p>Continued From page 2</p> <p>Observations on 8/23/12 at 2:16 PM with licensed nurse #1 and administrative nurse #2 revealed the left heel wound had not been redressed. The administrative nurse #2 did measurements of the wound. The left heel was observed directly on the bed. Drainage on the sheet was observed to be approximately 6 inches in diameter on one area, and 4 inches in diameter in a second area. Licensed nurse #1 provided wound care and a new dressing to the left heel wound.</p> <p>Interview with administrative nurse #2 on 8/23/12 at 2:30 PM revealed she usually measured the wounds. Further interview revealed the wound on Resident #2 was "improving."</p> <p>Interview with licensed nurse #1 on 8/23/12 at 3:00 PM revealed the floor nurses provide wound care and dressing changes. Further interview revealed wound care was provided when the medication pass was completed. The medications took priority over wound care. During this interview, licensed nurse #1 revealed any wound care or dressing changes that she could not provide by the end of her shift, was passed on to the next shift.</p> <p>Interview on 8/24/12 at 9:30 AM with nursing assistant #1 revealed she had informed licensed nurse #1 the dressing was off of Resident #2 's left heel around noon.</p> <p>Interview on 8/24/12 at 12:30 PM with administrative nursing staff member #1 revealed it was her expectation an uncovered wound would be redressed as soon as the nurse knew about it. The nurse may be involved in care with another resident, but should treat that resident next.</p>	F 314	<p>Charge nurses will document in the Treatment Administration Record (TAR) every shift that preventative measures have been checked and are followed as ordered.</p> <p>Nursing Management will complete an audit of resident wound treatments, documentation and placement of interventions daily x 2 weeks; twice a week x 1 month and then monthly x 2 months to ensure treatments have been completed and interventions are in place as ordered by the physician. Audits will be reviewed by the Director of Nursing Services (DNS) for any follow up needed. Results of the audits and follow up will be taken to the facility Performance Improvement (PI) meeting monthly x 90days.</p>	9/14/12

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F 314	<p>Continued From page 3</p> <p>During this interview, this staff member stated the wound should not be left uncovered for more than approximately fifteen minutes. After informing administrative nursing staff #1 the dressing had remained off the left heel wound of Resident #2 from 11:28 AM until 2:16 PM, she stated this was not an acceptable timeframe.</p> <p>Interview on 8/24/12 at 12:45 PM with administrative nursing staff member #1 revealed Resident #2 should have a pillow under the left lower extremity to keep the heel from pressing on the bed.</p> <p>Interview on 8/24/12 at 1:30 PM With licensed nurse #1 revealed she had not been informed Resident #2 had a dressing that had come off of the left heel wound. Information regarding residents would be communicated verbally between staff. Further interview revealed this staff member stated " When I went in, and pulled the covers back, I commented his dressing came off . "</p> <p>Interview on 8/24/12 at 1:45 PM with aide #1 revealed she had informed licensed nurse #1 of the dressing coming off of the left heel wound on Resident #2. Further interview revealed she had told her at the nurse ' s desk, after she had completed care for Resident #2.</p>	F 314			