STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	C 08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE RD ROXBORO, NC 27573

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F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to provide services to promote the healing of pressure ulcers by not doing weekly skin assessments that included staging and wound measurements for 2 of 4 residents, (Residents 4, and 2) reviewed for pressure ulcers. Findings included: 1. Resident #4 was admitted to the facility on 12/16/08 and had diagnoses that included dementia, failure to thrive, urinary tract infection and depression. The quarterly Minimun Data Set (MDS) dated 6/13/13 revealed the resident had an indwelling urinary catheter, was totally dependent for bed mobility, transfer, personal hygiene, was always incontinent of bowel, had one Stage 3 unhealed pressure ulcer. There was no measurement of the wound on the assessment. The care plan updated on 6/21/13 revealed a potential for skin breakdown - Stage 2 - left buttock fold. Interventions included body audits weekly and notify physician of any changes in status or skin breakdown.	F 314	1. Resident #4 skin assessment and wound measurements updated with correct measuring tool and correct units, centimeters. Staging completed by RN Care Managers. Care Plan and MDS updated. Treatment Nurse and or Care Managers will document weekly skin assessments, wound measurements, characteristics, and staging for accuracy and consistency via the weekly skin assessment form. Treatment nurse will notify RN Care Managers with any changes in staging, skin, and or wound characteristics. Hospice Provider educated on policy, accurate staging and measurement process and documentation on 8/22/13. Facility skin prevention and treatment policy and wound protocol revised and implemented for consistency and monitoring progress of wounds by Treatment Nurse and/or Care Managers. The policy and protocol was approved by the Clinical Quality Committee and the Medical Executive Committee on 8/17/13.	8/29/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: LNHA | (X6) DATE: 8/23/13

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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F 314	Continued From page 1 The Weekly Skin Assessment Sheets and nurse ' s notes were reviewed for 4/14/13 - 8/1/13 and revealed the following: The week of 4/14/13 there was no staging and no measurement of the wound. The week of 4/21/13 there was no staging and no measurement of the wound. The week of 4/28/13 there was no staging and no measurement of the wound. The assessment stated, " Sacral wound [treatment continued]. " The week of 5/5/13 there was no staging of the wound. The week of 5/12/13 there was no staging of the wound. The week of 5/19/13 there was no staging and no measurement of the wound. The assessment dated 5/21/13 indicated the resident had no skin impairment. The week of 5/26/13 there was no staging and no measurement of the wound. The assessment dated 5/26/13 stated, " Sacral wound continue. " The week of 6/2/13 there was no staging and no measurement of the wound. The assessment dated 6/4/13 indicated the resident had no skin impairment. The week of 6/9/13 there was no staging and no measurement of the wound. The assessment dated 6/11/13 stated, " Sacral wound [treatment continue]. " The week of 6/16/13 there was no staging of the wound. The week of 6/23/13 there was no staging and no measurement of the wound. The week of 6/30/13 there was no staging and no measurement of the wound. The week of 7/7/13 there was no staging and no measurement of the wound. The week of 7/14/13 there was no staging of the wound. The nurse ' s note dated 7/17/13 stated, "	F 314	2. All residents have updated and accurate skin assessments with proper staging and measurements completed by RN Care Managers. Care Plans and MDS were updated as required. Treatment Nurse and or Care Managers will continue weekly skin assessments and wound measurements. Care Managers will ensure weekly skin assessments are completed per policy. Documentation will be reviewed by DON monthly. 3. All staff and Physicians will be educated on revised policy, new wound protocol and importance of accuracy of measurements, staging, and consistency of documentation by 8/29/13. Initial skin assessment and or new wounds will be assessed by RN Care Managers. All Skin assessment Forms and protocols is part of the Treatment Administration Record. Treatment Cart was supplied with products to follow Wound Protocol and with appropriate wound measurement tools on 8/6/13.	

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F 314	Continued From page 2 Sacral wound 12 x 10. " The week of 7/21/13 there was no staging and no measurement of the wound. The week of 7/28/13 there was no staging of the wound. The nurse ' s note dated 7/31/13 stated, " Wound 4 x 1.5. " The treatment order dated 7/25/13 indicated cleanse sacral wound with cleanser, pat dry, apply hydrogel wafer then transparent film, changed every 5 days or soil or wet. An observation was made on 7/31/13 at 12:10 pm of wound care for Resident #4 ' s Stage 3 sacral wound being provided by the hospice nurse. She did not use a measuring tool or state the stage of the wound during the treatment and stated to Nurse #2, " Her wound is one and a half by four. " During an interview on 7/31/13 at 5:20 pm Nurse #2 indicated the hospice nurse had visually measured the resident ' s wound and that wounds should be measured with a measuring tool and reported in centimeters. The Chief Nursing Officer (CNO) was interviewed on 8/1/13 at 8:45 am and stated, " Skin assessments should be head to toe, turning residents and looking at everything. We do not have a wound cart with supplies, but that is something we are working on. We are looking at having [one assigned nurse] do all the wound assessments. Right now, different staff members are doing skin assessments, depending on their assignments. " She indicated that all wounds should be staged and measured with a measuring tool, not by sight alone, to ensure consistency and accuracy with measurements. She further indicated wounds should always be measured in centimeters per the Skin Impairment Prevention and Treatment Policy dated 10/2002. During an interview with Nurse #3 on 8/1/13 at	F 314	4. Monitoring of 100% of skin assessments will be completed weekly and findings discussed in the Interdisciplinary meetings. Care Plans and MDS will be revised to reflect needs of the Residents. Results will be presented to the ECU QA Committee monthly and the Clinical Quality Committee monthly. The wound protocol and the Skin Prevention and Treatment Policy will be part of orientation and annual training. 5. Compliance with all skin assessments and updated documentation will be completed by August 29, 2013. 1. Resident #2 skin assessment, measurements, and staging has been completed by the RN Care Manager. The Care plan and MDS have also been updated. Treatment Nurse and or Care Managers will continue weekly skin assessments and wound measurements via the weekly skin assessment form. Treatment nurse will notify RN Care Managers with any changes in skin and wound characteristics. The Skin Prevention and Treatment Policy will be followed and physicians made aware of any changes that occur.	

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F 314	Continued From page 3 10:25 am she indicated she does weekly skin/wound assessments and that documentation is done either on the skin sheets or in nurse ' s notes. She also indicated there was not a system to monitor the increase or decrease in wound size, and that each nurse would have to look several places if she wanted to know the last wound measurement. 2. Resident #2 was originally admitted to the facility on 10/7/11 and most recently readmitted on 7/15/13. She had diagnoses that included Rheumatoid arthritis, osteoporsis, history of falls, depression, urinary tract infection, and dementia. The quarterly Minimun Data Set (MDS) dated 5/3/13 revealed the resident was severely cognitively impaired based on staff interview, was at risk for pressure ulcers, did not have any pressure ulcers, did not participate in the assessment, was totally dependent for bed mobility, transfer, eating, and personal hygiene. The care plan most recently updated on 4/25/13 stated, " Resident at risk for skin breakdown or pressure ulcers related to decreased mobility. No skin breakdown at this time. " The Weekly Skin Assessment Sheets and nurse ' s notes were reviewed for 5/26/13 - 8/1/13 and revealed the following: The nurse ' s note dated 5/26/13 indicated a skin tear to the left elbow. The Weekly Skin Assessment Sheet dated 6/6/13 indicated a " skin tear " to the left elbow. The Weekly Skin Assessment Sheet dated 6/13/13 indicated a " skin tear " to the left elbow. The nurse ' s note dated 6/21/13 indicated Resident #2 had a, " left elbow skin tear 2 x 1. " The Weekly Skin Assessment Sheet dated 6/27/13 stated, " Open sore draining yellow " to the left elbow. The Weekly Skin Assessment Sheet dated 7/7/13	F 314	2. All Residents have updated and accurate skin assessments with proper staging and measurements completed by RN Care Managers. Care Plans and MDS updated as required. Treatment Nurse and or Care Managers will continue weekly skin assessments and measurements and staging. Care Managers will have have responsibility to ensure weekly skin assessments are completed per policy. Documentation will be reviewed by the DON monthly. 3. All staff and physicians will be educated on the revised policy, new skin protocol, and the , importance of accuracy of measurements, staging and documentation consistency by 8/29/13. Initial skin assessments and or new wounds will be assessed and staged, and measured by RN Care Managers. All skin assessments forms and protocols are part of the Treatment Administration Record. The Treatment Cart was supplied with products to follow Skin Care Protocol and appropriate wound measurement Tools on 8/6/13.	

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F 314	Continued From page 4 stated, " Open area to (left) elbow. " The physician order dated 7/17/13 stated " clean left elbow with normal saline, pat dry, pack lightly with calcium alginate silver. Cover with nonadherent dressing [daily] and [as needed]. " The nurse ' s note dated 7/17/13 indicated Resident #2 had a " 5 x 3 " wound to the left elbow. During an interview with Nurse #2 on 7/31/13 at 11:30 am she indicated Resident #2 had a pressure ulcer on her left elbow and received daily wound care for the ulcer. During an interview on 8/1/13 at 12:44 pm Nurse #1 stated the wound on Resident #2 ' s left elbow, " Started out as a skin tear, became inflamed, and is now a pressure sore. " There was no staging of the resident ' s wound noted in her record.	F 314	4 .Monitoring of 100% of skin assessments will completed weekly and discussed with the Interdisciplinary meetings. Care Plans and MDS Will be revised to reflect needs of the resident. Results will be presented to The ECU QA Committee and Clinical Quality Commiittee monthly. Skin Care Protocol and the Skin Prevention and Treatment Policy will be part of orientation and annual Training 5. Compliance with all skin assessments and wound staging and measurement documentation will be completed by August 29, 2013.	