

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

OCT 04 2013

PRINTED: 09/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345466	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/12/2013
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 333 EAST LEE STREET YADKINVILLE, NC 27055	
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F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, surgeon 's nurse interview and record review the facility failed to maintain a dressing on a surgical site of a revised above the knee amputation for one of one sampled residents with a surgical site. Resident #1</p> <p>The findings included:</p> <p>Resident #1 had an initial admission on 6/27/13 with diagnoses of diabetes, end stage renal disease and gangrene. The most recent readmission from the hospital was on 8/27/13 with diagnoses of peripheral vascular disorder, end stage renal disease, a revision of an amputation and wound infection. Review of the Minimum Data Set (MDS) dated 7/4/13 indicated Resident #1 had a surgical wound with treatment and dressings to the surgical site. This MDS assessed Resident #1 with no impairment in long or short term memory. Review of the care plan dated 7/12/13 indicated a problem of recent right above the knee amputation with diagnoses of gangrene, peripheral vascular disease, diabetes and wound infection. Approaches included provide</p>	F 309	<p>Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or correctness of the conclusions set forth on the statement of deficiencies, the plan of correction is prepared and submitted solely because of the requirements under State and Federal law.</p> <p>This Plan of Correction will serve as the Facility's allegation of substantial compliance</p> <p>F309</p> <p>1. The dressing was applied to the Resident #1's surgical wound by the Wound Care Nurse on 9/12/2013. Frequent checks are in place to ensure that Resident #1's surgical wound is covered. Resident #1 no longer resides in the facility.</p>	

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

Ima Billings CNHA

TITLE

Executive Director

(X6) DATE

10/2/2013

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 309	Continued From page 1 treatments per physician orders. Review of the hospital admission record dated 8/22/13 revealed Resident #1 had a below the knee amputation, followed by an above the knee amputation (AKA) due to non healing wound of the stump in July 2013. Currently Resident #1 was admitted for treatment of wound infection with intravenous antibiotics and debridement of the stump wound. Review of the most recent physician orders dated 9/10/13 were to use Santyl (debriding agent) to the right AKA wound daily, cover with moist saline gauze and dry dressing. An oral antibiotic was ordered due to wound infection. Observations at 8:15 AM on 9/12/13 revealed the dressing was off the right AKA wound exposing an open area on the inner side of the surgical incision. Observations were made on 9/12/13 at 9:50 AM, 11:25 AM 12:05 PM, 2:10 PM and 3:00 PM and the surgical wound was exposed with no dressing intact. Interview on 9/12/13 at 8:15 AM with Resident #1 revealed the dressing had come off during the night. " The dressings do not stay on the stump and keep coming off. " Resident #1 was asked if the nurses were aware the dressing was off, and she replied " yes. " Interview with the floor nurse for Resident #1 on 9/12/13 at 10:00 AM revealed she did not do wound care, only passed the medications. A treatment nurse would do the dressings. Interview with the treatment nurse on 9/12/13 at 1:30 PM revealed the stump surgical wound had changed in appearance on 9/10/13. The wound " came open " and Resident #1 was sent out to the surgeon the next day. The surgeon did debridement of the wound and took out staples. The treatment to the open wound included packing with Santyl, and gauze soaked with	F 309	2. For residents currently residing in the facility with wounds, observations were conducted by the Director of Clinical Services or Nurse Manager on 9/16/2013 to ensure that dressings were present per physician's order to decrease risk of infection. No other residents were found to be effected. 3. Re-education was provided by the Director of Clinical Services or Nurse Manager on 9/30/2013 to nursing staff regarding physician's orders for treatment administration per physician's order and ensuring that dressings remain intact to cover wounds to prevent infection. The education also included reporting wounds that are not covered to a licensed nurse so that the treatment/dressing can be re-applied per physician's orders and the wound remains covered to prevent infection.		

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F 309	Continued From page 2 normal saline. Cover the wound with a dry dressing and change it every day. The treatment nurse was not aware the wound had been uncovered since some time that morning. The treatment nurse explained she had come in late today and had not arrived until around 11:30 AM. The wound should be kept covered with the treatment intact. Interview with the vascular surgeon ' s nurse on 9/12/13 at 2:25 PM revealed the wound was supposed to be kept covered to prevent further infections. The resident had recent infections in the wound. The dressing would help prevent further wound infection. Interview with the Director of Nursing on 9/12/13 at 4:00 PM revealed any nurse could replace a dressing on a wound.	F 309			
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, resident and staff interviews and record review the facility failed to report and change in skin condition and implement a pressure reduction device for one of one resident with a history of pressure ulcers.	F 314	4. Random observations of residents with wounds will be made by the Director of Clinical services or Nurse manager and documented on a Quality Improvement monitoring tool 5 times per week for 4 weeks; 3 times per week for 4 weeks; 2 times per week for 4 weeks; then weekly for 4 weeks to ensure that wounds have treatment applied per physician's order and that wounds are covered by appropriate physician's ordered treatment. Results of these random weekly observations will be discussed at the monthly Quality Assurance Committee Meeting for 6 months by the Executive Director the Director of Clinical Services for review for required changes/revisions to the process to sustain substantial compliance.	10-1-13	

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F 314	<p>Continued From page 3 Resident #1</p> <p>The findings included:</p> <p>Resident #1 was re-admitted to the facility on 8/27/13 with diagnoses including diabetes, end stage renal disease, revision of a right above the knee amputation and wound infection.</p> <p>Review of the medical record revealed a history of pressure ulcers on the sacrum. An order dated 6/29/13 for treatment to a .25centimeter (cm) by .8 cm open area on sacrum with soap and water. Apply antibiotic ointment and dry dressing. The dressing to be changed daily until healed.</p> <p>Review of a telephone order dated 7/13/13 revealed treatment of a sacral wound to be cleansed with soap and water and barrier cream applied.</p> <p>Review of the care plan updated on 8/16/13 revealed a problem of being at risk for developing further skin breakdown due to incontinent episodes and decreased mobility. The approaches for staff to use included a pressure reducing cushion to wheelchair. A problem of alteration in elimination with incontinent episodes listed an approach for nursing staff to observe resident ' s skin with all incontinent care and inform nurse of any skin changes noted during perineal care.</p> <p>Admission data dated 8/27/13 indicated there was no redness on the sacrum or buttocks. The Braden scale used to assess the risk of developing pressure ulcers indicated Resident #1 was at "Severe Risk" for pressure ulcers</p>	F 314	<p>F314</p> <p>1.For Resident #1, a cushion was placed in her recliner as well as her wheelchair by the Director of Clinical Services on 9/12/2013. The care plan and kardex were updated to reflect this intervention. Resident #1 no longer resides in the facility.</p> <p>2.For other residents currently residing in the facility that are at risk for pressure ulcers, a review of current interventions was completed by the Director of Clinical Services or Nurse Manager on 9/16/2013. Additional interventions were implemented as deemed necessary and the care plans and kardex were updated to reflect these interventions.</p>		

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F 314	Continued From page 4 The Minimum Data Set (MDS) dated 9/3/13 assessed Resident #1 as requiring extensive assistance with bed mobility, transfers, hygiene, toileting and was non ambulatory. This MDS indicated Resident #1 had no long or short term memory impairments. There were no pressure ulcers present or healed during this assessment. Resident #1 was " at risk " for developing pressure ulcers. Interventions to be used included a pressure relieving cushion in the wheelchair. Review of the Treatment Administration Record for the month of September revealed orders to check for placement of a cushion in a wheelchair. This had been initialed by the nurses as being in place. Observations on 9/12/13 at 8:15 AM of Resident #1 revealed she was seated in a recliner with a lift sling under her buttocks. Interview on 9/12/13 at 8:15 AM with Resident #1 revealed she had been in the recliner since approximately 5:00 AM. Further interview revealed she did not like to sleep or stay for long periods of time in her bed. She stated " I smother. " Observations of Resident #1 on 9/12/13 at 10:19 AM revealed she was transferred by aide #1 and aide #2 from the recliner to the bed. Resident #1 had been sitting on a sling with a cut-out open area where her buttocks rested. After being transferred to the bed, aide #1 and #2 removed the disposable brief and provided incontinence care for Resident #1 due to a bowel movement. Observations revealed the buttocks to be bright	F 314	3.Re-education was provided by the Director of Clinical Services or Nurse Manager on 9/30/2013 to nursing staff with regards to ensuring that interventions are implemented as indicated for those at risk for pressure ulcers. Re-education was also provided to nursing staff by the Director of Clinical Services or Nurse Manager to include notification to charge nurse regarding changes in skin condition. For residents residing in the facility at risk for pressure ulcers, a random weekly review as well as direct observation was conducted by the Director of Clinical Services or Nurse Manager of care plans and kardex to ensure that interventions		

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F 314	<p>Continued From page 5</p> <p>red. Aide #1 stated an area of bleeding was observed. The buttocks were cleansed and a barrier cream was applied.</p> <p>Interview on 9/12/13 at 1:15 PM with the floor nurse for Resident #1 revealed a foam cushion in the wheelchair. The cushion was used on days she traveled to dialysis.</p> <p>Interview with the treatment nurse on 9/12/13 at 1:30 PM revealed Resident #1 did not have any treatments to the sacrum.</p> <p>Observations of Resident #1 were made with the Director of Nursing on 9/12/13 at 4:25 PM. Resident #1 had been transferred from the bed to the recliner about fifteen minutes earlier. There was not cushion not in the recliner chair.</p> <p>Interview of Resident #1 by the DON revealed she would like to have the cushion in her recliner and didn ' t know she could have one. Resident #1 further stated (she) " Didn't know it could be moved from w/c to recliner. " Resident #1 stated her bottom felt better, but she had been in the bed all day.</p> <p>Interview on 9/12/13 at 4:20 PM with the treatment nurse revealed she had not provided any treatments or conducted an assessment of Resident # 1 ' s buttocks. Continued interview revealed she was not informed by the aides to look at the resident ' s buttocks. The treatment nurse explained the aides usually told her of any skin problems when found during the provision of care.</p> <p>An interview was conducted on 9/12/13 at 4:28 PM with the floor nurse working the 3-11 shift on Resident #1 ' s hall. Interview with this nurse revealed she was not aware of any skin issues on</p>	F 314	<p>were documented and to ensure that documented interventions were implemented as indicated. This weekly random review will be conducted/ completed at a frequency of 5 times per week for 4 weeks; 3 times per week for 4 weeks; 2 times per week for 4 weeks; then weekly for 4 weeks.</p> <p>4. The results of the random weekly observations will be discussed at the monthly Quality Assurance/Performance Improvement Committee for 6 months by the Executive Director or Director or Clinical Services for review for required changes/revisions to the process to sustain substantial compliance.</p>	10-1-13	

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F 314	Continued From page 6 the resident's buttocks. Further interview revealed she was not told by the 7-3 Nurse Resident #1 had any skin problems. Interview with the unit manager on 9/12/13 at 4:30 PM revealed she was not aware of any skin issues for Resident #1. She had not been informed of redness or bleeding on Resident #1 ' s buttocks. The aide reported Resident #1 " was sleeping, and they were not getting her up. " Interview with the MDS nurse on 9/12/13 at 5:00 PM revealed the recliner was " soft " and the nurses documented the cushion was in the wheelchair. When asked if there was an intervention in place while Resident #1 was seated in the recliner she said there was not.	F 314		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review the facility failed to secure a lift pad to the total lift during a transfer, resulting in injury for one of three sampled residents. Resident #1 The findings included: Resident #1 was admitted to the facility on	F 323	F323 1.For Resident #1, vital signs were obtained by nurse on 8/28/2013. MD and the RP were notified on 8/28/2013. The resident was transferred to the hospital for treatment on 8/28/2013. Resident #1 no longer resides in the facility. 2.No other residents were found to be affected. Regarding other residents requiring lift transfers, re-education was provided by the Director of Clinical Services or Nurse Manager on 9/30/2013 to nursing staff regarding appropriate utilization of the lift to include properly securing the lift pad to the total lift during transfer with a return demonstration by nursing staff.	

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F 323	<p>Continued From page 7</p> <p>6/27/13 with diagnoses including diabetes and lower extremity wounds. A readmission on 8/27/13 revealed a diagnosis of revision of an amputation of the right leg.</p> <p>The Minimum Data Set (MDS) dated 7/4/13 indicated Resident #1 required extensive assistance of two staff with transfers, extensive assistance with bed mobility and was non ambulatory. Resident #1 was alert and oriented with no impairment in short or long term memory. The care plan dated 7/12/13 addressed a problem of potential falls. Approaches for staff to use for fall prevention included provide therapy as ordered, encourage resident to call for assistance as needed, assist resident with turning and reposition, assist resident with transfers and Hoyer lift for transfers.</p> <p>Review of the care information in the care plan note book for direct care staff "Kardex" (with no date) revealed instructions to transfers Resident #1 "with assist of 2, full body lift."</p> <p>An assessment "Transfer Quarterly Summary ..." dated 8/22/13 indicated Resident #1 required a two person assist for transfers and use of a total lift.</p> <p>Review of the nurses' notes dated 8/28/13 at 4:30 AM revealed an aide went into the resident's room to get her up. In the process of transferring Resident #1 with the lift, the sling slipped off the hook of the lift. The aide and a family member were able to grab Resident #1 and lower her to the floor. Resident #1 sustained a skin tear to the right arm, and a skin tear to the lower left leg. The lower leg skin tear was approximately 6 to 8 inches. Resident #1 was alert and oriented to person, place and time. Per family request, Resident #1 was sent to the emergency room for evaluation and treatment.</p>	F 323	<p>3. Nursing staff have been educated by the Director of Clinical Services or Nurse Manager on 9/30/2013 regarding transfers, appropriate utilization of the lift, and where to find the appropriate information for individual resident transfers.</p> <p>Re-education was also provided by the Director of Clinical Services or Nurse Manager on 9/30/2013 to nursing staff regarding the appropriate utilization of the lift pad to the total lift during a transfer. Transfer assessments were completed for residents residing in the facility by the Director of Clinical Services or Nurse Manager by 9/2/2013 including newly admitted and re-admitted residents. Resident care plans and kardex were updated by The Director of Clinical Services or Nurse Manager to correspond with transfer assessments on 9/16/2013.</p>		

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F 323	Continued From page 8 Review of the emergency room physician ' s report dated 8/28/13 revealed the left lower leg laceration was treated with 11 stitches and measured 8 centimeters. The fall investigation dated 8/29/13 revealed two to three staff members did not assist in the transfer. The fall committee review and recommendations included educating staff on the use of the total lift, all lifts were checked and the aide was removed from duty during the investigation. Interview with Resident #1 on 9/12/13 at 8:15 AM revealed she had a fall from the total lift and cut her left leg. The aide was using the lift, and the pad came loose when she was raised up in the lift. Interview on 9/12/13 at 9:42 AM with aide #2 revealed care information about Resident #1 was provided in a care plan note book kept at the nurse ' s desk. Aide #2 reported Resident #1 required assistance by two staff for all of her activities of daily living except eating. A total lift and two staff were required for transfers for Resident #1. Interview with the therapy manager on 9/12/13 at 10:12 AM revealed Resident #1 had several admissions to the hospital with readmissions to the facility. On the first admission, training was done with nursing staff on how to transfer Resident #1 and protect the right leg amputation. The resident was to be transferred using a total lift with two staff members. Interview with the Administrator on 9/12/13 at 12:50 PM revealed an investigation was conducted with the aide involved in the lift incident. A statement was provided by the aide describing the incident. The aide was aware she was to have 2 staff for use of lift. She did not explain why she did not find another staff member	F 323	The Director of Clinical Services or Nurse Manager has observed a transfer for nursing employees to ensure that appropriate transfer technique is being demonstrated during resident transfers. Nurses and CNAs have been required to demonstrate a transfer successfully before they can work another shift. This will include newly hired nursing employees. Random weekly observations of transfers will be conducted by the Director of Clinical Services or Nurse Manager for three (3) employees to ensure that appropriate transfer technique is being sustained by nursing staff during resident transfers.		

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F 323	Continued From page 9 for assistance. During the application of the lift pad, the aide was in a hurry to apply the pad. She acknowledged she had training during orientation on the use of the lift. The aide also documented she was aware another staff member was to be present when a total lift was used for transfer. Interview with the Director of Nursing (DON) on 9/12/13 at 2:52 PM revealed aides were aware of the facility requirement for total lifts to have two staff members. A return demonstration had been done on orientation with use of the lift. During the investigation of the lift incident with Resident #1, the aide demonstrated how the lift pad/sling was applied to the lift. The DON revealed one loop on the corner of the pad/sling was not secured in the lift hook. The corner at the shoulder of Resident #1 was not secured which caused the resident to slide out of the pad/sling. The aide said Resident #1 slid head first not leg first and was caught before hitting the floor by the aide and a family member. Further interview revealed it was her expectation nursing staff was to have 2 staff present during the use of the total lift. If there was not another aide available, the aide was to obtain help from their nurse.	F 323	4.Results of weekly observations will be discussed at the monthly Quality Assurance/ Performance Improvement Meeting by the Executive Director or Director of Clinical Services for six (6) months. Revisions will be discussed and implemented as needed to sustain substantial compliance.	10-1-13	