STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345492	A. BUILDING _____ B. WING _____	C 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC STATE VETERANS NURSING HOME	214 COCHRAN AVENUE FAYETTEVILLE, NC 28301

(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 record review, observations, staff and physician interviews, the facility failed to 1) ensure that the medical record reflected the care and treatment provided 2) correctly assess and classify skin impairment for 1 of 3 residents that was at risk for skin breakdown (Resident #1). Findings included: Resident #1 was admitted into the facility on 4/24/14. Diagnoses included diabetes, stroke, hemiplegia or hemiparesis and general muscle weakness. The admission minimum data set completed on 5/1/14 indicated Resident #1's cognitive pattern was moderately impaired. Rejection of care was not indicated. Extensive assistance of one person physical assist was required with bed mobility. Total dependence of one person physical assist was required for toilet use, personal hygiene (one person physical assist) and bathing (two person physical assist) was listed. Bowel and urinary continence was listed as "always incontinent." Skin condition was indicated at risk for pressure ulcers with no unhealed or current pressure ulcers. Skin treatment included pressure reducing device for bed, turning and repositioning program and applications of ointments/medications (other than feet). The care plan dated 4/24/14 indicated Resident #1 was at risk for skin impairment. The care plan updated on 5/5/14 indicated "risk for skin breakdown due to left side hemiplegia and	F 281	Step #1: Resident #1 affected 5/18/14 per nurses's note. Area was identified on 5/18/2014 and healed on 6/4/2014. Step #2: Residents with potential to be affected are any residents with a wound(s) not described per policy. Step #3: Systemic changes/Interventions All nurses (RN/LPN) will be in-serviced on the wound policy and staging of wounds.. Step #4: Plan to monitor Wound care notes will be evaluated during AM Clinical Rounds when new wound care orders are written to ensure compliance. Monitoring will continue by the Unit Managers (RN), Performance Improvement Nurse (RN), and Director of Nursing (RN) x 3 months and reported to the Performance Improvement (PI) Committee at the month meeting for review and recommendations as needed per the committee and reports.	6/13/14 6/13/14 6/18/14 6/18/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Whitney Bell	LNHA	6/13/14

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 281	Continued From page 1 incontinence of bowel/bladder." The care area assessment (CAA) completed on 5/7/14 listed risk for pressure ulcer as a potential problem. Extrinsic risk factors in part included: requires regular schedule turning and required staff assist to move sufficiently to relieve pressure over any one site. Intrinsic risk factors included: immobility, altered mental status and incontinence. The CAA narrative notes concluded "risk for skin breakdown due to bedfast and incontinence of bowel and bladder, has no skin breakdown and skin assessed daily with morning care." A review of the body audit form completed on 4/25/14 by treatment Nurse #1 revealed a body diagram in which the buttock area was circled with hyper/hypo pigmentation with peeling skin and redness. The braden scale (a tool used for predicting pressure ulcer risk) scored the following: 4/25 (moderate risk), 5/1 (moderate risk), 5/8 (moderate risk), 5/16/14 (moderate risk). A review of the medical record did not reflect the care provided (barrier application or cream) to the impaired skin areas to the buttocks from 4/25/14 through 5/3/14, as assesed by Nurse #1. A review of the wound observation and assessment form dated 5/5/14 completed by Nurse #1 revealed slight excoriation to the buttocks and groin area. The buttock was indicated as remained with peeling skin and slight redness. Prevention measures included skin barrier. The treatment record from 5/4/14 though 5/20/14 reflected zinc ointment was ordered to be applied to excoriation areas posterior to the scrotum and calazime cream to the groin every shift.	F 281		

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F 281	Continued From page 2 A review of the "documentation of wound observation and assessment form" completed by treatment Nurse #1 on 5/20/14 indicated in part: type of wound "excoriation - open area, location: sacral/buttocks, wound bed: thin yellowish covering, surrounding skin: peeling, measurement: 0.2 centimeter (cm) [length] x 0.1 cm [width], wound edges: 1-3" with no drainage or sign/symptoms of infection or pain. Note: excoriation refers to a superficial loss or surface loss of the skin such as a scratch. During an observation on 5/20/14 at 8:50 am, Resident #1 was positioned in bed in a supine (back) laying position. The head of the bed was positioned at 45 degrees. During a care observation on 5/20/14 at 11:10 am, completed by nursing assistants (NAs #1, #2), Resident #1 required the assistance of NA #1 to turn him over on his side (toward the window), supported by NA #2 while NA#1 provided incontinence care. Resident #1's brief was observed saturated with yellow matter/content. Upon completion of washing with soap and water, then rinsing of the groin and buttocks areas, an opened area was observed to the upper mid buttock/sacral with yellow tissue matter in the center of the opened area, with redden surrounding tissue. At 11:12 am, Nurse #2 when asked to assess the area indicated the area was "opened" and that she would get the treatment Nurse. She concluded she was not aware to date that Resident #1 had this opened area. At 11:15 am, the treatment nurse (Nurse #1) when asked to assess the area stated that she observed an "opened area with a yellowish center excoriation to the upper sacral/buttock with surrounding skin	F 281		

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F 281	Continued From page 3	F 281		

intact and blanchable, that was not pressure related." Nurse #1 concluded that she was not aware to date that Resident #1 had this opened area.

In an interview on 5/20/14 at 12:35 pm, Nurse #1 when questioned regarding Resident #1 opened area to his upper mid buttocks/sacral area, she stated that her assessment of the area revealed the skin was opened with the wound bed/center of the area noted with yellowish-tan tissue, that she would classify as "excoriated because the skin is opened." When further questioned related to the body audit assessment that she completed on 4/25/14, and what preventive treatment was started per her assessment that Resident #1 buttocks was observed redden, with peeling skin and discoloration, (hypo/hyper pigmentation); she indicated that she started the resident on "calazime with zinc skin barrier ointment to aide in healing." Nurse #1 acknowledged that Resident #1 was incontinent of urine. She indicated that she did not initiate a physician order for the barrier ointment (calazime with zinc), nor did she transcribe the barrier ointment to the treatment record or medication record after she completed her assessment on 4/25/14. When asked to show in the medical records where the ointment application was applied from 4/25/14 to 5/3/14, Nurse #1 stated that the medical record did not reflect that such care was provided during this time frame.

During an observation on 5/20/14 at 1:40 pm, Resident #1 required the assistance of two nursing staff to transfer from the wheelchair into the bed. Resident #1 was observed able to pivot with general weakness. Upon placing the resident in the bed he required one person physical assist

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F 281	Continued From page 4 to remove his clothing. Accompanied by the treatment nurse (Nurse #1), the physician and the director of nursing (DON), Resident #1's upper mid sacral/buttock area was assessed by the physician and the DON, after the barrier cream (calazime cream) was washed away with soap and water from the buttocks/sacral area. In an interview on 5/20/14 at 1:50 pm, the physician accompanied by the director of nursing and the treatment nurse, the physician when questioned regarding his assessment observation indicated that his assessment revealed a "Stage II pressure ulcer." He elaborated "It is a stage II because the epidermis and dermis skin layers are broken and the area is not going into the deep tissue." When questioned if the area could be considered excoriation he stated "No, the area is physically opened through the epidermis/dermis layers of the skin." The DON when questioned regarding her assessment stated that she expected the nursing staff to follow the facility's wound protocol and notify the physician. At 2:00 pm, the physician asked for permission to exit the interview per statement "I need to speak with the DON." At 2:55 pm, the physician returned and stated that he wanted to clarify his previous statement that he should not have said the ulcer was pressure related because the resident is able to reposition himself independently in the chair and bed. He indicated that he was not sure what the etiology (cause) of the ulcer was, so today he would say it is a "Stage II lesion non-pressure related that is not excoriation."	F 281		