STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345537	A. BUILDING _____ B. WING _____	C 06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER STREAM HEALTH AND REHABILITATION CENTER	2305 SILVER STREAM LANE WILMINGTON, NC 28401

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F 314 SS=E	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 record review, observations and interviews the facility failed to complete weekly skin assessments on a resident at high risk of developing pressure ulcers, failed to measure and assess a blister (right heel) after it was identified and failed to implement treatments as ordered for a blister (right heel) for 28 of 44 days (Resident #1) for 1 of 3 sampled residents. The findings included: Resident #1 was admitted to the facility on 4/2/14 with diagnoses including Protein Calorie Malnutrition, Chronic Anemia, Chronic Kidney Disease Stage IV, Status Post Hip Fracture with Hemiarthroplasty, Urinary Retention, Edema and History of Prostate and Lung Cancer. Review of the Admission Minimum Data Set Assessment dated 4/8/14 identified Resident #1 as cognitively intact, having a poor appetite, having no behaviors, requiring extensive two person assistance with bed mobility, transferring, dressing and toilet use, and extensive one person	F 314	F314 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 is being accomplished by: A. The affected resident is no longer in this facility but to make sure this does not happen to other residents: All residents currently in the facility are to have a head to toe skin assessment. This will be completed by 6/20/14. B. All residents with identified pressure ulcers, the charts will be audited dweekly to ensure appropriate documentation and treatment is carried out. C. Licensed nursing staff will be	6/20/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/26/2014

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F 314	Continued From page 1 assistance with bathing. Resident #1 was assessed as having functional imitation in range of motion on one side of his lower extremity. He had an indwelling urinary catheter and was continent of his bowel. Resident #1 had no pressure ulcers on admission. He had a surgical wound to the right hip area. Review of the Care Area Assessment (CAAs) Summary dated 4/15/14 identified the area of Pressure Ulcer triggering related to decreased mobility and recent hip surgery. Review of the Care Plan for Pressure Ulcers dated 4/15/14 assessed Resident #1 as having a potential to develop pressure ulcers related to his decreased activity and impaired mobility. Approaches listed, in part; in meeting the goal of having intact skin included completing a full body check weekly and documenting. Review of the laboratory values dated 5/19/14 documented Resident ' s Hemoglobin at 8.3 (low) and Hematocrit 26.5 (low) and Albumin level was 2.0 (low). On 5/21/14 his Hemoglobin was 7.7 (low) and Hematocrit 24.7 (low). Resident #1 received two blood transfusions during his stay. Review of the Admission Skin Assessment dated 4/2/14 identified that Resident #1 had no pressure ulcers on admission and had multiple scratches over arms, trunk and legs. Review of the Head to Toe skin check dated 4/3/14 identified Resident #1 as having intact skin. Review of the medical record showed no full body check done weekly for Resident #1 after 4/3/14	F 314	re-educated on facility skin management and medication Management Systems, which includes weekly skin checks, documentation requirements adhered to, measurement and treatment of all wounds, preventive skin care and proper transcription of doctors' orders. D. Unit coordinator to check weekly skin audit sheets for 4 weeks. 1. Corrective action by those patients that may be affected by the deficient practice practice is: All residents currently in the faciity will have a head to toe skin assessment completed. Any areas identified will be treated appropriately. 2. For every patient that has the potential to be affected by the deficient practice we have completed a complete skin assessment on every patient in the building and we now have a system in place whereby all new residents being admitted will be placed in our monitoring system and this will prevent any issues with skin or doctor orders being carried out timely. 3. To be assured the deficient practice will not occur again: Upon admission the patient will have their skin assessment completely in a timely manner, this will be completed weekly and each unit manager will follow up with the monitoring weekly of the skin assessments on their hall. If any areas found that are not following the procedure, the unit manager will immediately implement 1 on 1 inservice education for that employee. All of the monitoring systems that are in place willl be taken through the QAPI committee	

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F 314	Continued From page 2 until his discharge on 5/23/14. Review of the Weekly Pressure Ulcer Record dated 4/7/14 identified superficial open areas to the left and right buttock. All areas were a Stage II. The treatment included Endit Cream to the area. The areas on the left and right buttocks healed on 5/5/14. Review of the medical record showed no documentation reflecting the initial assessment of the right heel blister on 4/9/14. Review of a verbal Physician ' s order dated 4/9/14 received by the Treatment nurse, documented an order for Skin Prep to the right heel blister TID (three times daily). Review of the Treatment Administration Record (TAR) for April 2014 did not document the order for Skin Prep to the right heel. Review of the TAR for May 2014 documented treatment began to the right heel blister on 5/3/14. Review of the Nursing Notes from 4/9/14 until discharge showed no documentation related to a right heel blister. The nursing note dated 4/9/14 reads " open area on butt/sacral area " . Review of the Physician ' s Progress Note dated 4/23/14 documented that Resident #1 ' s right heel was soft and felt like a blister secondary to his resting in bed with heels on bed. The plan was to continue with heel protectors and elevate heels off of the bed. Further review of the Physician ' s Progress note dated 4/25/14 documented Resident #1 ' s right heel had a blister now draining and wound care would evaluate.	F 314	monthly to be assured of continued compliance. This will be completed for 4 months. 4. The above measures outlined will be taken to the QAPI Committee every month which will evaluate the effectiveness of the systems by monitoring the corrective action for 4 consecutive months for compliance. This facility alleges compliance of F314 by 6/20/14. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the providerf of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law".	

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F 314	Continued From page 3 Review of a verbal Physician Order dated 5/8/14 received by the Treatment nurse, documented to clean right heel with normal saline, pat dry, apply skin prep and to apply normal saline wet-to-moist and cover with bordered gauze. The dressing was to be monitored every shift for placement. Review of the Weekly Pressure Ulcer Record dated 5/19/14 documented a blister of the left heel (Stage II). The area was open. The wound bed was pink and the skin around the blister was normal for color and intact. The treatment included cleaning the area with normal saline, patting dry and applying skin prep and covering daily. Review of the Treatment Administration Record documented treatments as being done. Heel protectors were in use. Resident #1 was discharged home prior to the next assessment. Review of the medical record documented Resident #1 was up daily for Physical Therapy. Review of the Orthopedic Consult dated 5/22/14 documented Resident #1 ' s progress has been limited by dizziness, tremors, weakness with minimal effort during strength training, fatigue, poor motivation to stay out of bed other than when up for therapy. During an interview with the Treatment nurse on 6/5/14 at 9:30am it was stated that there was an order on 4/9/14 for treatment to the right heel but the order was not transcribed to the April TAR. He also stated that he did not remember a blister to the right heel and if the Physician ' s Assistant wanted an evaluation to the area an order would have been written and there was no order. He	F 314		

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F 314	Continued From page 4	F 314		

also stated that the nursing staff is responsible for the weekly skin assessments and there were no assessment found in the chart. He stated that Resident #1 was compromised from recent hip surgery; he was weak and liked to stay in bed. He did wear heel protectors while in bed.

During an interview with Nurse #1 on 6/5/14 at 10:00am she stated that she worked with Resident #1 but could not recall which heel had the blister. She also stated that she worked with the resident on 4/9/14 but did not recall doing the weekly skin check. She also stated that on 4/9/14 when she signed the order as the receiving nurse for the Skin Prep to the right heel blister she may have forgotten to transcribe the order to the TAR.

During an interview with the Physical Therapist 6/5/14 at 10:15am she stated Resident #1 came to the therapy room everyday. After therapy he was taken back to his room and he always went back to bed per his preference. She stated if he wasn ' t in therapy, he was in bed as he lacked motivation.

During an interview with the Director of Nursing on 6/5/14 at 10:20am she stated there should have been something documented if Resident #1 had a blister develop on 4/9/14 but no assessments could be found. She stated it would be expected that weekly skin assessments be done and that physician ' s orders be followed.

During an interview with the Administrator on 6/5/14 at 1:15pm she stated it is expected that weekly skin checks would be done and that physician ' s orders would be followed and treatments would not be delayed.

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