

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2014
NAME OF PROVIDER OR SUPPLIER PETTIGREW REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1515 W PETTIGREW STREET DURHAM, NC 27705		
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F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: The facility failed to update a care plan for a problem of pressure ulcers with the use of positioning a device to prevent pressure ulcers for one of four sampled residents with pressure ulcers. Resident #49.</p> <p>The findings included: Resident #49 was admitted to the facility on 6/21/14 with diagnoses including viral blood infection, malnutrition and arthritis.</p> <p>The " Patient Nursing Evaluation " completed on</p>	F 280	<p>F280 and F314</p> <p>1. Resident #49 care plan has been updated to reflect rolled towel is to be placed between knees except during provision of care. Resident #49 currently has a rolled towel between her knees, when she allows. Resident #49 care plan has been updated to reflect she does not always keep the towel between her knees.</p> <p>2. Residents with pressure ulcers have been referred to Physical Therapy and</p>	10/24/14	

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

TITLE

(X6) DATE

Electronically Signed

10/15/2014

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 280	<p>Continued From page 1</p> <p>6/21/14 indicated Resident #49 entered the facility with a 1.0 x 1.5 stage 2 wound on the right knee.</p> <p>The Minimum Data Set (MDS) dated 6/28/14 indicated Resident #49 required extensive assistance with bed mobility and total assistance from staff for all other activities of daily living. The MDS assessed Resident #49 as being always incontinent of bowel and bladder. Pressure ulcers were assessed on the MDS as a stage 4.</p> <p>Review of the weekly pressure ulcer reports for Resident #49 for the weeks of 6/21/14 to 7/11/14 revealed the right knee pressure area healed on 7/11/14.</p> <p>The Occupational Therapy (OT) discharge summary, dated 7/31/14 indicated Resident # had an abductor wedge that was given by the therapist. The OT indicated staff needed to use regular follow through with the device to ensure the resident 's skin integrity. In addition to using the wedge positioning device, a rolled up towel was to be used in between thighs while lying in bed. The therapist indicated " nursing staff consistently following through with request for these skin integrity interventions and applying them correctly. "</p> <p>The updated care plan for 8/6/14 for a problem of impaired skin integrity did not include the positioning devices recommended by OT for preventions of a pressure ulcer.</p> <p>Interview with the MDS nurse on 9/25/14 at 1:40 PM revealed she was not aware OT had recommended positioning devices to be used for</p>	F 280	<p>Occupational Therapy for positioning. Therapy will provide written recommendations, as needed, to the DON. The DON, ADON, SDC, Therapist or MDS Coordinator will in-service the nursing staff on therapy recommendations as well as update the resident's care plan and care card.</p> <p>3. Newly admitted residents with pressure ulcers and residents who acquire pressure ulcers will be referred to Physical Therapy and Occupational Therapy for positioning. Therapy will provide written recommendations, as needed, to the DON. The DON, ADON, SDC, Therapist or MDS Coordinator will in-service the nursing staff on therapy recommendations as well as update the resident's care plan and care card. Physical Therapy and Occupational Therapy staff will be in-serviced to provide the DON with written recommendations ongoing. Weekly for three months, during Focus Resident at Risk Meetings, the Rehab Manager and the DON will audit the residents who were referred to Physical Therapy and Occupational Therapy for positioning, the recommendations from therapy, the resident care plan and the resident care card will be reviewed to validate all recommendations have been care planned. The DON, ADON, SDC or MDS Coordinator will conduct weekly observation audits for three months on residents with pressure ulcers to validate care planned interventions related to pressure ulcer are implemented consistently over time.</p>		

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F 280	Continued From page 2 pressure ulcer prevention.	F 280			
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, record review and staff interviews the facility failed to implement recommended positioning devices for pressure ulcer prevention for one of four sampled residents with pressure ulcers. Resident #49.</p> <p>The findings included:</p> <p>Resident #49 was admitted to the facility on 6/21/14 with diagnoses including viral blood infection, malnutrition and arthritis.</p> <p>The " Patient Nursing Evaluation " completed on 6/21/14 indicated Resident #49 entered the</p>	F 314	<p>4. Results of the audits will be presented to the center's Quality Assurance and Performance Improvement Committee monthly for a minimum of three months for review and further recommendations to sustain compliance ongoing.</p> <p>F280 and F314</p> <p>1. Resident #49 care plan has been updated to reflect rolled towel is to be placed between knees except during provision of care. Resident #49 currently has a rolled towel between her knees, when she allows. Resident #49 care plan has been updated to reflect she does not always keep the towel between her knees.</p> <p>2. Residents with pressure ulcers have been referred to Physical Therapy and Occupational Therapy for positioning. Therapy will provide written</p>	10/24/14	

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F 314	<p>Continued From page 3</p> <p>facility with a 1.0 x 1.5 stage 2 wound on the right knee.</p> <p>The Minimum Data Set (MDS) dated 6/28/14 indicated Resident #49 required extensive assistance with bed mobility and total assistance from staff for all other activities of daily living. The MDS assessed Resident #49 as being always incontinent of bowel and bladder. Pressure ulcers were assessed on the MDS as a stage 4.</p> <p>Review of the weekly pressure ulcer reports for Resident #49 for the weeks of 6/21/14 to 7/11/14 revealed the right knee pressure area healed on 7/11/14.</p> <p>The Occupational Therapy (OT) discharge summary, dated 7/31/14 indicated Resident # had an abductor wedge that was given by the therapist. The OT indicated staff needed to use regular follow through with the device to ensure the resident ' s skin integrity. In addition to using the wedge positioning device, a rolled up towel was to be used in between thighs while lying in bed. The therapist indicated " nursing staff consistently following through with request for these skin integrity interventions and applying them correctly. "</p> <p>The updated care plan for 8/6/14 for a problem of impaired skin integrity did not include the positioning devices recommended by OT for preventions of a pressure ulcer.</p> <p>The weekly pressure ulcer assessment dated 8/6/14 assessed the right knee wound as a stage 2 pressure ulcer. The date of onset for the wound was 8/6/14. The wound measured 0 .6</p>	F 314	<p>recommendations, as needed, to the DON. The DON, ADON, SDC, Therapist or MDS Coordinator will in-service the nursing staff on therapy recommendations as well as update the resident's care plan and care card.</p> <p>3. Newly admitted residents with pressure ulcers and residents who acquire pressure ulcers will be referred to Physical Therapy and Occupational Therapy for positioning. Therapy will provide written recommendations, as needed, to the DON. The DON, ADON, SDC or MDS Coordinator will in-service the nursing staff on therapy recommendations as well as update the resident's care plan and care card. Physical Therapy and Occupational Therapy staff will be in-serviced to provide the DON with written recommendations ongoing. Weekly for three months, during Focus Resident at Risk Meetings, the Rehab Manager and the DON will audit the residents who were referred to Physical Therapy and Occupational Therapy for positioning, the recommendations from therapy, the resident care plan and the resident care card will be reviewed to validate all recommendations have been care planned. The DON, ADON, SDC or MDS Coordinator will conduct weekly observation audits for three months on residents with pressure ulcers to validate care planned interventions related to pressure ulcer are implemented consistently over time.</p> <p>4. Results of the audits will be presented</p>		

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F 314	<p>Continued From page 4</p> <p>centimeters (cm) in length by 0 .8 cm in width.</p> <p>The telephone orders dated 8/6/14 included treatment to the right knee with normal saline to clean the wound. Alginate and a foam dressing were to be applied and changed every day.</p> <p>Interview with nurse #1 on 09/23/2014 at 9:09:56 AM revealed Resident #49 had a healing stage 4 on the right knee. Nurse #1 explained the wound was considered pressure due to knee to knee pressure.</p> <p>Observations of Resident #49 on 9/22/14 at 10:00 AM revealed the abductor wedge was not used while the resident was observed in a Broda chair.</p> <p>Observations on 9/24/14 at 2:06 PM revealed Resident #49 did not have rolled towels between her thighs/legs while in bed.</p> <p>Observations on 9/24/14 at 3:04 PM revealed Resident #49 had no rolled towels between her thighs/legs. The knees were touching skin surface to skin surface on the inner aspect of the knees.</p> <p>Observations on 9/25/14 were made at 9:50 AM, 11:05 AM and 12:50 PM and revealed Resident #49 was in bed with the knees touching. A dressing was in place on the right knee. A rolled towel or any other positioning device had not been placed between her knees or legs to prevent skin to skin contact.</p> <p>Observations on 9/25/14 at 11:05 AM revealed the resident was out of bed in a Broda chair. Positioning devices were not used between the resident ' s knees/legs. The wound was in the</p>	F 314	to the center's Quality Assurance and Performance Improvement Committee monthly for a minimum of three months for review and further recommendations to sustain compliance ongoing.		

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

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F 314	<p>Continued From page 5</p> <p>middle of the resident ' s right knee cap. The wound was small in size, about .5 centimeters. The wound bed had granulation tissue present and did not appear to have any depth.</p> <p>Interview with aide #1 was conducted on 9/25/14 at 2:08 PM. Aide #1 had provided care for Resident #49 on 9/24/14. Interview revealed the resident was total care. Resident #49 had "hard type boots" on both feet and wore the boots all the time. Further interview with aide #1 revealed she was not aware of any other positioning devices to be used for Resident #49.</p> <p>Interview with the treatment nurse on 9/25/14 at 11:15 AM revealed Resident #49 had entered the facility with the right knee wound. The wound had a scab and it came off. This nurse explained the wound was " looking better. "</p> <p>Interview with the treatment nurse revealed pillows were used for positioning devices. She did not recall a wedge or rolled towels being used for positioning.</p> <p>Interview with OT on 9/25/14 at 12:45 PM revealed the wedge for use in the chair did not work well for the resident. Nursing staff were instructed by OT to use the rolled towel between the legs when she was in and out of bed. Further explanation provided by the OT revealed the rolled towels were to prevent the contracted knees from touching skin to skin. He was not aware of any refusals to allow the rolled towels for positioning between the knees.</p> <p>Interview with aide #2 09/25/2014 at 12:51:24 PM revealed she was assigned to the resident for that date. Aide #2 explained she was not aware of any positioning device to be placed between the</p>	F 314			

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F 314	<p>Continued From page 6</p> <p>resident's knees/legs. Further interview revealed the aides had information about the care to be provided to residents on a resident care card. The cards were kept in a notebook for the aide ' s information on resident care.</p> <p>Review of the resident care card for Resident #49 revealed the use of the positioning devices were not listed as an intervention for positioning or skin prevention.</p> <p>Interview with the Director of Nursing on 9/25/14 at 12:55 PM revealed nursing received communication from therapy during daily meetings of any new positioning devices for residents. Therapy would also communicate any new devices to be used for residents to the floor nurses. Further interview revealed she was not aware positioning devices for Resident #49 had been recommended. The expectation of the Director of Nursing for the nursing staff would be to use pillows for positioning even if therapy had not recommended devices.</p> <p>Interview with the Assistant Director of Nursing and nurse #2 on 9/25/14 at 1:08 PM revealed they both made rounds with the wound physician. It was explained Resident #49 had the pressure ulcer on the center of her knee due to criss crossing of her legs. The pressure came from one knee pressed on top of the other knee. Further interview revealed neither nurse was aware of the recommendations by OT for use of a rolled towel as a positioning device to prevent pressure between the knees.</p>	F 314			