STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345544	A. BUILDING _____ B. WING _____	C 02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY CARE CENTER	3625 WILLARD FARROW DRIVE CHARLOTTE, NC 28215

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F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of the medical record, the facility failed to notify the physician of a change in skin temperature when	F 157	1. Resident #1 that was affected was transferred to the emergency department for further evaluation. The resident's	3/20/15

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

Electronically Signed | 03/20/2015

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F 157	Continued From page 1 the left lower leg of a resident became cold to touch. (Resident #1) The findings included: Resident #1 was admitted to the facility 09/24/14. Diagnoses included vascular dementia, hypoalbumenia, coronary artery disease, cerebrovascular disease, congestive heart failure (CHF), hypercholesterolemia, low vitamin D levels and hypertension. A physician's admission progress note dated 09/25/14, revealed Resident #1 was admitted with small amounts of dependent edema in her feet and ankles. On admission (09/25/14) Resident #1 was assessed with a suspected deep tissue injury (SDTI) to the left heel which measured 1 cm by 1 cm. The skin was intact with dark purplish discoloration noted. A physician's order dated 09/26/14 documented to apply skin prep and mepilex (foam dressing) with dressing changes every Monday, Wednesday, and Friday. Resident #1 received nutritional support via a frozen nutritional supplement twice daily, ice cream with 1 teaspoon coconut oil added once daily, and 4 ounces of a high calorie nutritional supplement three times daily with medication administration. Review of the wound progress notes revealed the SDTI was assessed as healed on 12/15/14. A physician's progress note dated 10/23/14 assessed Resident #1 with 2+ edema in her bilateral lower extremities. The physician wrote orders for Lasix (diuretic) 30 milligrams (mg) daily, to increase Coreg to 12.5 mg daily, start potassium chloride 10 milliequivalents daily,	F 157	responsible party was notified of the resident's change of condition. Completed on 2/1/15 by the RN Supervisor. 02/01/15 2. All residents at Asbury Care Center were assessed for significant changes. Each Supervisor assessed residents for potential changes of condition. No other significant changes were noted on assessment. Completed on 2/25/15 by the RN Supervisor. 02/25/15 3. All nurses will utilize their autonomy in notifying a physician for any residents change of condition. Nurses will log any resident changes in the physician communication book and alert the RN Supervisor of these changes. The RN Supervisor will then assess the resident's change and determine if the proper notification to the physician has occurred. If the residents change of condition is significant and warrants notification of the physician, resident and/or responsible party will be notified. Staff will be educated on this process on or before 03/19/15. 03/19/15 4. The RN Supervisor will note in the Shift Report(Supervisor Communication Tool) any notification to physicians of significant changes in a residents condition. This will be monitored weekly by Director of Nursing/Designee and discussed with Medical Director for evaluation whether	

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F 157	Continued From page 2 complete blood tests on Monday 10/27/14 (basic metabolic panel (BMP) and b-type natriurectic peptide (BNP) and monitor for signs/symptoms of overt CHF. On 10/30/14 the physician reviewed the lab results from 10/27/14 for Resident #1 and noted that the results confirmed mild CHF due to an elevated BNP; no new orders were written. On 11/20/14 a physician's order was written for medium strength (20-30 mm) knee high compression hose to be applied daily to Resident #1's bilateral lower extremities in the am and removed in the pm. A nurse's note dated 11/29/14 noted Resident #1 with a scab to her left lower extremity (LLE) opening due to persistent use of compression hose. A note was placed in the physician's communication book for evaluation. On 12/05/14 Resident #1 was noted with a dry scab to her LLE. A physician's order dated 12/05/14 was written to apply a bioclusive dressing, change as needed and to monitor the LLE dry scab for infection. A wound progress note dated 01/21/15 noted Resident #1 had an open wound to her LLE that was previously a dry scab. The wound measured 2.5 cm by 1.5 cm with dark red tissue to the wound bed, erthythema to the periwound, with moderate dark serosangueous drainage, infection, swelling and complaints of pain noted. A physician's order dated 01/21/15 noted to cleanse the wound with wound cleaner, apply xeroform, a dry dressing and wrap with kerlix daily.	F 157	proper action was taken. This information will be discussed at monthly Quality Assurance meetings X 6 months. 03/23/15 The RN Supervisor staff will be educated on 03/20/15 the process of reporting significant changes on Supervisor Communication Tool. 03/20/15	

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A physician's progress note dated 01/22/15 documented Resident #1 had a skin tear to the LLE, swollen and red left foot/ankle, with possible cellulitis. On 01/22/15 a physician order for an Xray of the left foot/ankle was completed and an order for Bactrim DS (antibiotic) twice daily for 8 days was initiated. The radiology report dated 01/22/15 was negative for a fracture, negative for osteomyelitis and noted minimal osteoarthritis at the distal toes of the left foot.

A nurse's note dated 01/23/15 documented Resident #1's LLE was very tender when touched.

A nurse's note dated 01/26/15 documented Resident #1's LLE appeared very red at the time. A wound progress note dated 01/26/15 documented that Resident #1's LLE was noted with more redness, assessed by the supervisor with a call placed to the physician and the family. The physician was notified and gave an order to obtain a complete blood count (CBC) with differential. The lab results dated 01/27/15 revealed Resident #1 had an elevated white blood cell count (11.6), indicative of an infection.

A physician's order dated 01/27/15 indicated to start Rocephin (antibiotic) 1 gm IM (intramuscular) daily for 7 days due to wound infection, encourage/measure food/fluids each shift for 72 hours, obtain a CBC with differential on 01/29/15, and culture the open wound to the LLE. The wound culture report dated 01/28/15 revealed Resident #1's LLE wound was positive for a staphylococcal infection.

A physician's order dated 01/30/15 indicated to discontinue Rocephin, start Gentamicin

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(antibiotic) 40 mg IM every 12 hours for 7 days due to a wound infection and obtain a BMP on Monday 02/02/15.

A nurse's progress note dated 02/01/15 at 8:10 AM noted Resident #1 with toes to left foot pale in color, cold to touch and that Resident #1 did not respond to stimuli to the left foot/toes. A note was written in the physician's communication book and a supervisor was informed.

A nurse's progress note dated 02/01/15 at 5:45 PM, documented this registered nurse was requested by a nurse to assess the LLE for Resident #1 which was being treated for a wound infection. The registered nurse noted that the Resident's left foot was dark purple in color, cold to touch with no response to physical stimuli to the left foot. The family was notified.

On 02/01/15 at 6:15 PM Resident #1 was transferred to the emergency department (ED) for evaluation of her left leg/foot per the family's request and physician's order.

An interview on 02/25/15 at 9:00 AM with nurse #1 (wound nurse) revealed nursing staff informed her on 12/03/14 that Resident #1 had a scabbed area to the LLE. Nurse #1 stated she assessed it on 12/05/14, treated it with a bioclusive dressing and continued to treat/monitor until 01/07/15 at which time nursing staff provided treatment/monitoring. Nurse #1 stated on 01/21/15 nursing staff asked her to assess Resident #1's LLE. Nurse #1 stated she assessed Resident #1's LLE and noted the scabbed area was now open, larger than when she saw it on 01/07/15, and the surrounding skin was dark purple. Nurse #1 stated she asked

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nurse #3 (supervisor) to look at the wound and notified the physician because the wound was worse than when she last saw it on 01/07/15. Nurse #1 further stated she continued to treat the wound, was off 01/24/15 and 01/25/15, Saturday/Sunday, and when she saw Resident #1 again on Monday, 01/26/15, the wound was worse and she notified the physician. Nurse #1 further stated that at some point the week of 01/26/15, the Resident's left leg was cold to touch, but she was not sure on what date. Nurse #1 stated she last treated Resident #1's LLE wound on 01/30/15 and noted the leg was swollen, and the surrounding skin around the wound was darker than the week before. She stated that she would typically try to obtain pedal pulses, but because the Resident's LLE was so swollen, a pedal pulse was hard to get.

On 02/25/15 at 09:13 AM a telephone interview was conducted with nurse #2 and revealed she was the assigned nurse for Resident #1 on the 11 PM to 7 AM shift on 01/31/15. Nurse #2 stated a nurse aide asked her if anyone had informed her that Resident #1's LLE looked "dead". Nurse #2 stated she noted Resident #1's LLE to be purple in color and "ice cold". The Resident's LLE did not respond to any stimuli. Nurse #2 stated she last saw Resident #1's LLE on Tuesday 01/27/15, but it was not like that, "cold as ice", when she saw it on Tuesday. Nurse #2 informed her supervisor (nurse #5) and the oncoming nurse (nurse #4) to advise her supervisor (nurse #6).

On 02/25/15 at 10:28 AM, a telephone interview was conducted with nurse #5 (night supervisor). Nurse #5 stated during the 11 PM - 7 AM shift on 01/31/15, nurse #2 asked her to take a look at the LLE wound for Resident #1. Nurse #5 stated she

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assessed Resident #1's LLE wound around 06:00 AM for the first and only time and the Resident's left foot was cold and purple. Nurse #5 stated she reviewed Resident #1's medical record and saw where the physician had changed antibiotics because the Resident's LLE wound was not getting better. Nurse #5 stated she did not call the physician or report this to the oncoming shift since the Resident's LLE wound was being treated and thought the physician was already aware. Nurse #5 stated she did not obtain a pedal pulse for the Resident's LLE.

On 02/25/15 at 10:53 AM, a telephone interview was conducted with nurse #6 (supervisor) who stated she worked 7 AM to 7 PM every weekend. Nurse #6 stated she saw Resident #1's LLE wound for the first time on 02/01/15 at the request of nurse #4 and noted the LLE was cold to touch and dark purple. Nurse #6 stated a pedal pulse could not be obtained. Nurse #6 stated she contacted the family to determine how aggressive the family wanted treatment to be and the family requested that Resident #1 receive everything that could be done for her LLE. Nurse #6 stated when she saw Resident #1's leg she sought guidance from the family because at that point, the condition of the Resident's leg required further evaluation.

On 02/25/15 at 10:56 AM, nurse #3 (supervisor) was interviewed and stated that she assessed Resident #1's LLE on 01/26/15 around 3:20 PM at the request of nurse #1. Nurse #3 stated she noted Resident #1 LLE was red, swollen, and warm, but not hot. Nurse #3 stated she did not obtain pedal pulse to the Resident's LLE, but did call the physician. The physician ordered a CBC

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with differential on 01/26/15 and on 01/27/15 an antibiotic and wound culture.

An interview on 02/25/15 at 12:01 PM with nurse #4 revealed she was not the routine nurse for Resident #1 and did not work with the Resident often. Nurse #4 stated she was the assigned nurse for Resident #1 on the 3 PM - 11 PM shift on 01/31/15 for the first time in a while. Nurse #4 stated she administered a Rocephin injection to Resident #1 during the shift and noted the LLE was cold to touch and dark purple. Nurse #4 stated she informed nurse #2, the 11 PM - 7 AM nurse that the Resident's LLE was cold. Nurse #4 further stated nurse #2 looked at Resident #1's LLE and reported to her supervisor. Nurse #4 stated she did not try to obtain a pedal pulse, she did not document a nurse's note regarding the condition of the Resident's LLE and she did not notify the physician that Resident #1's LLE was cold to touch, but realized now that she should have. Nurse #4 stated she worked on 02/01/15 from 7 AM- 11 PM and when she arrived on shift, she was told that Resident #1's LLE was not responding to any stimuli. Nurse #4 began her medication pass and sometime after 3:00 PM on 02/01/15 she completed a dressing change for Resident #1 to the LLE which was the first time she observed Resident #1's LLE that day. Nurse #4 stated she noted the LLE to be cold and skin surrounding the wound was black. Nurse #4 stated she advised her supervisor, nurse #6, who called the family and physician and Resident #1 was transferred to the ED on 02/01/15 around 6 PM.

A telephone interview was conducted on 02/25/15 at 12:44 PM with the physician. He stated he would have expected the nurse to contact him on

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F 157	Continued From page 8 01/31/15 when Resident #1's LLE was noted cold to touch. The physician stated he either would have come to see the Resident, that day if possible, or sent her out to the hospital at that time for further evaluation. The physician further stated it would not have made any difference in the prognosis for Resident #1, however, due to her advanced age and the poor circulation in her LLE that was getting worse. An interview with the director of nursing (DON) occurred on 02/25/15 at 12:54 PM. The DON stated all the nurses have the autonomy to contact the physician and advise him if there is a change in condition for a resident. The DON further stated that a registered nurse (supervisor) was available on each shift and could assist in the assessment of a resident to help decide if the physician should be contacted. The DON also stated that a nurse should not assume what the physician had been made aware of, but rather should contact him when a change in a resident's condition occurred.	F 157		