| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345151 | A. BUILDING _____ B. WING _____ | C 08/13/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHITE OAK MANOR - KINGS MOUNTAIN | 716 SIPES STREET KINGS MOUNTAIN, NC 28086 |

| (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 |
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| F 314 SS=D | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews, a physician interview and medical record review, the facility failed to maintain a protective dressing intact, per physician's order, to an unstageable left heel pressure ulcer for 1 of 3 sampled residents with pressure ulcers. (Resident #12)<br><br>The findings included:<br><br>Resident #12 was admitted to the facility on 05/01/15. Diagnoses included decubitus ulcer of the foot, adult failure to thrive, advanced Alzheimer's dementia, wound infection, cellulitis and abscess of the foot.<br><br>Review of Resident #12's May 2015 care plan revealed a risk for further skin breakdown. Interventions included in part to provide treatments as ordered for protection, daily skin assessments by a licensed nurse, monitor the skin with routine care for changes and to notify the physician of changes.<br><br>Review of a pressure ulcer skin report dated | F 314 | This facility does 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.<br><br>Resident #12 does have a protective dressing intact per physicians orders.<br><br>All other residents with pressure ulcers maintain a protective dressing intact, per the physicians orders.<br><br>The N.A. #2 was re-educated one on one by the Staff Development Coordinator on 8/12/2015 regarding notifying the nurse if a dressing is noted soiled, dislodged or missing. | 9/10/15 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 09/02/2015 |

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| F 314 | Continued From page 1<br>05/01/15 revealed Resident #12 was admitted to the facility with an unstageable left heel pressure ulcer.<br><br>A physician's order dated 05/01/15 recorded to cleanse the left heel pressure ulcer with normal saline solution, pat dry, apply Santyl (a treatment for debridement) to the wound bed, cover with 2 cm by 2 cm gauze and a foam dressing daily.<br><br>A quarterly minimum data set dated 07/28/15 assessed Resident #12 with severely impaired cognition, required extensive staff assistance with bed mobility, total staff assistance with transfers, at risk for the development of pressure ulcers and one unhealed pressure ulcer.<br><br>A pressure ulcer skin report dated 08/12/15 documented Resident #12's unstageable left heel pressure ulcer was a visual stage 2 wound that measured 0.5 cm by 0.3 cm by 1 cm with scar tissue extending at 12 o'clock, no necrotic tissue, irregular wound edges and to continue treatment plans.<br><br>Resident #12 was observed on 08/12/2015 at 08:40 AM in bed covered with a blanket after being fed breakfast by nurse aide (NA) #1. Resident #12's ankles were observed supported on a pillow and her heels positioned off the bed. A dressing was not observed intact to her left heel. During the observation, NA #1 stated that she had not yet provided morning care to Resident #12. NA #1 stated that she did not see a dressing to the Resident's left heel and after looking in the bed covers, NA #1 stated that she did not see a dressing loose in the bed. NA #1 also stated that she was not aware that Resident #12 did not have an intact dressing to her left heel. | F 314 | The Nursing Staff was re-educated starting 8/14/2015 though 8/31/2015 by the Staff Development Coordinator regarding of a dressing is noted soiled, missing, or dislodged that the nurse must be notified immediately and dressing to be replaced per physicians order.<br><br>A skin dressing monitor log was developed to monitor the skin areas that have orders for dressings maintain a protective dressing intact, per the physicians order. These logs will be reviewed by the R.N. Supervisor or designee to assure continued compliance with F314. This will be monitored daily x 90 days.<br><br>Results from the monitoring will be discussed during weekly Quality Assurance Meetings for its effectiveness. Any identified issues will be corrected per the Quality Assurance Team recommendations. Unresolved issues will be reviewed by the Director of Nursing or designee for follow up re-education.<br><br>The Director of Nursing is responsible for the on-going compliance of F314. | |

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| F 314 | Continued From page 2 | F 314 | | |

On 08/12/15 at 09:01 AM nurse #1 (treatment nurse) stated that Resident #12 should have a foam dressing with a sticky border intact to her left heel. Nurse #1 stated "It should be there, I have not looked this morning; staff will remove it when she is going to get a shower, but they tell me so I can redress it."

On 08/12/2015 at 9:14 AM, nurse #2 stated that she had not observed the left heel for Resident #12 yet that morning and she was not aware that a dressing was not intact to her left heel. Nurse #2 stated there was no reason the dressing was not intact.

A wound care observation occurred on 08/12/2015 at 09:23 AM with nurse #1. During the observation, nurse #1 stated that Resident #12 did not have a dressing intact to her left heel and that a loose dressing was not found in the bed covers. Nurse #1 stated that she changed the left heel dressing for Resident #12 the prior day around 8 AM, dated and initialed the dressing and was not aware that the dressing was not intact. Nurse #1 stated that she provided wound care to residents Monday thru Friday and at times she had observed Resident #12 without an intact dressing to her left heel when she provided wound care on a Monday morning. Nurse #1 stated when this occurred she questioned staff, but never got an answer as to what happened to the dressing. Nurse #1 stated that Resident #12's left heel pressure ulcer still required a dressing for protection.

NA #2 stated in interview on 08/12/2015 at 12:14 PM that she provided a shower to Resident #12

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| F 314 | Continued From page 3 | F 314 | | |

the day before around 11:00 AM and a dressing was intact to the Resident's left heel. NA #2 stated during the shower the dressing came off and she forgot to tell the nurse. NA #2 stated "I forgot, but I know that's something I should have told the nurse."

A follow up interview with nurse #2 occurred on 08/12/15 at 12:45 PM and revealed she had not been informed the day before by NA #2 that Resident #12's dressing to her left heel came off during her shower. Nurse #2 stated "I should have been told." Nurse #2 further stated had she been made aware that Resident #12 was without an intact dressing to her left heel, she would have contacted the physician to obtain an order to order to reapply a dressing.

On 08/12/2015 at 4:26 PM nurse #3 stated she was the nurse for Resident #12 on the 3 PM - 11 PM shift the prior day. Nurse #3 stated she did not observe the left heel for Resident #12 during the shift; she had not been informed that a dressing was not in place and she could not say whether or not a dressing was intact to her left heel

On 08/12/2015 at 4:51 PM NA #3 stated she worked the 11 PM - 7 AM shift the prior day. NA #3 stated she did not remember specifically seeing a dressing to Resident #12's left heel and may have forgotten to let the nurse know.

On 08/12/2015 at 4:53 PM nurse #4 stated she worked the 11 PM - 7 AM shift the prior day. Nurse #4 stated that she had not routinely monitored the left heel for Resident #12 on her shift to ensure a dressing was intact. Nurse #4 stated she expected the nurse aides to inform her

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| F 314 | Continued From page 4<br>if a resident's dressing came off or was not intact.<br><br>During a telephone interview on 08/13/2015 at 12:11 PM, the physician stated that Resident #12 had end stage dementia; her left heel wound was improving, but that he did not expect the left heel pressure ulcer to completely heal. The physician further stated that he expected the physician's order for wound care to be followed. The physician stated Resident #12's left heel wound should be dressed, if the wound were not dressed temporarily like for bathing, that was okay, but the wound should not be uncovered for an extended period of time.<br><br>On 08/13/2015 at 4:20 PM, the director of nursing stated she expected the nurse aide to inform the nurse if a resident's dressing was observed not intact. | F 314 | | |
| F 367 SS=D | 483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN<br><br>Therapeutic diets must be prescribed by the attending physician.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews and medical record review, the facility failed to provide pureed bread to 1 of 3 sampled residents with a physician's order for therapeutic diets. (Resident #12)<br><br>The findings included:<br><br>Resident #12 was admitted to the facility on 05/01/15. Diagnoses included dysphasia, adult | F 367 | This facility provides therapeutic diets that are prescribed by the Attending Physician.<br><br>Resident #12 is receiving pureed bread and her therapeutic diet as ordered by the Attending Physician.<br><br>All other residents are receiving diets as ordered by the Attending Physician. | 9/10/15 |

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| F 367 | Continued From page 5<br>failure to thrive and advanced Alzheimer's dementia.<br><br>Medical record review revealed a physician's order dated 05/28/15 which recorded to provide Resident #12 with a puree plus (calorie enhanced) diet.<br><br>Review of the May 2015 care plan revealed Resident #12 had self care deficits, swallowing problems and was at risk for nutritional compromise related to cognitive deficits, dementia and a history of unplanned weight loss. Interventions included for staff to feed Resident #12 a mechanically altered diet as ordered, monitor her tolerance of a pureed diet and report any intolerance to the speech therapist.<br><br>A quarterly minimum data set dated 07/28/15 assessed Resident #12 with severely impaired cognition, required a mechanically altered therapeutic diet and total staff assistance with eating.<br><br>On 08/12/15 at 8:23 AM, Resident #12 was observed in bed with the head of the bed raised. Resident #12 was edentulous and was fed her breakfast meal by nurse aide (NA) #1. Resident #12 received a pureed diet of oatmeal seasoned with sugar and jelly, pureed ham seasoned with salt, a slice of toasted bread, a glass of cola and a glass of orange juice. Review of the tray card on the meal tray recorded Resident #12 was to receive a pureed plus diet and beverages without straws. NA #1 stated that she fed Resident #12 "from time to time", and stated "I feed her enough to know what she likes." NA #1 stated that she was aware that Resident #12 received a pureed | F 367 | Re-education was provided to the Dietary Staff 8/12/2015 through 8/14/2015 by Dietary Management regarding following therapeutic diets as prescribed by the Physician. Re-education was provided to the Nursing Department 8/12/2015 through 8/14/2015 by the Staff Development Coordinator on proper meal serving and checking the diet card prior to serving the meal to the resident.<br><br>Monitoring logs were developed to monitor diets being served following Physician Orders. These logs will be reviewed by the Dietary Manager or designee to assure compliance of F 367. This will be monitored daily during meals x 90 days.<br><br>Results from the monitoring will be discussed during weekly Quality Assurance Meetings for its effectiveness. Any identified issues will be corrected per the Quality Assurance Team recommendations. Unresolved issues will be reviewed by the Dietary Manager or designee for follow up re-education.<br><br>The Dietary Manager is responsible for the on-going compliance with F367. | |

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diet. Resident #12 ate 100% of her pureed oatmeal and pureed ham. On 08/12/15 at 08:30 AM, NA #1 was observed to cut the slice of toasted bread into small pieces and put a piece of the toasted bread to the mouth of Resident #12 with a fork. When asked if toasted bread was part of the pureed diet for Resident #12, NA #1 stated "I have seen her get toast before, but I have never fed it to her before, so I will try it and we will see what happens." The surveyor asked NA #1 to check with the nurse before feeding Resident #12 toast. NA #1 covered the Resident's breakfast meal and left the room. On 08/12/15 at 08:35 AM, NA #1 returned and stated "The nurse said for me not to attempt it because the nurse was not sure if she could eat it." Nurse #2 followed NA #1 into the room and asked "Where is the toast?" NA #1 responded "Under the lid, I did not give it to her." Nurse #2 said "Ok, don't give her the toast." Nurse #2 exited the room.

Review of the breakfast menu on the therapeutic spreadsheet for 08/12/15 revealed a pureed diet should receive pureed bread.

During an interview on 08/13/15 at 3:14 PM dietary staff #1 stated that each resident's tray ticket recorded the diet and meal preferences that were to be followed. Dietary staff #1 further stated that when plating foods or setting up the meal tray, staff used the therapeutic spreadsheet to know which foods to offer according to the resident's diet. Dietary staff #1 stated that residents with a diet order for a pureed diet should receive pureed bread, not a slice of toasted bread.

During an interview on 08/13/15 at 3:16 PM the assistant dietary manager (ADM) stated she

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expected her staff to follow the menu spreadsheet, reviewed/approved by the consultant dietitian, which recorded the diet and what should be served for each meal. The ADM stated residents with a physician's order for a pureed diet should receive pureed bread and stated "They should never receive regular bread." The ADM further stated she tried to monitor the tray line for each meal for accuracy, but at times she was only able to "spot check". The ADM stated Resident #12's breakfast tray left the kitchen on 08/12/15 with a slice of toasted bread in error and this should not have happened.

On 08/13/2015 at 3:41 PM, the rehab director stated that there was the potential for swallowing difficulty with solid foods for a resident with a diagnosis of dysphasia and a physician's order for a pureed diet. He further stated resident's who received a pureed diet were at risk for not having the ability to chew and swallow solid foods sufficiently without choking and therefore pureed foods should be provided.

On 08/13/2015 at 4:20 PM, the director of nursing stated she expected residents with a physician's order for a pureed diet to receive pureed bread and not toast.