STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW HILL, NC 28580

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F 314 SS=D	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 observation, record review, and staff interviews, the facility staff did not report the development of an unstageable pressure area to the left heel in a timely manner for 1 of 3 residents (Resident #102) who had pressure ulcers. Findings included: The facility's "PRESSURE ULCER PREVENTION" program, version 11-2012, noted to inspect skin and notify the appropriate personnel of abnormal changes. It was noted that skin inspections were done in different ways. It indicated that the inspections were done many times a day during daily care by the nurse aides and licensed personnel. It was documented that if abnormalities were found they were to be noted. Resident #102 was admitted to the facility on 06/15/15. Cumulative diagnoses included lung cancer, hypertension, atrial fibrillation and hemiplegia. The most recent Quarterly Minimum Data Set (MDS) assessment of 09/09/15 documented she was cognitively intact and required extensive to total assistance from staff	F 314	Greendale Forest Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that this summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care for the residents. The plan of correction is submitted as a written allegation of compliance. Greendale Forest Nursing and Rehabilitation Center's response to the Statement of Deficiencies and the Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greendale Forest Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the stated deficiencies on the Statement of Deficiencies through informal dispute	11/8/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/03/2015

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F 314	Continued From page 1 for all activities of daily living. She was incontinent of both bowel and bladder. There were no pressure ulcers noted. The "Preventative Interventions" form of 07/07/15 noted Resident #102 was to be turned and repositioned and wore a specialized boot. She was on a pressure relieving mattress. Laboratory results of 07/24/15 noted a low serum albumin and a low serum protein. A dietary supplemental of 08/10/15 noted Resident #102 was receiving Resource 2.0 (supplement) 120 milliliters three times daily. A health status note from Nurse #1 of 09/22/15 at 1:42 PM documented that a nurse aide stated "...she has had dark area on L (left) heel for a while but thought we were aware". Bunny boots were in place. The area was described as dark and hard. It was cleaned with soap and water. The treatment nurse was notified. Physician orders were obtained for Vitamin C and zinc as well as an albumin level. The family was notified. A physician's telephone order of 09/22/15 noted to provide Vitamin C 500 milligrams twice daily for 14 days and zinc 220 milligrams for 14 days. A wound ulcer flow sheet for Resident #102 of 09/22/15 documented an unstageable pressure ulcer to the left heel that occurred in house. It was described as being 100% black. Treatment included painting with betadine daily and covering with a foam dressing. A wound ulcer flow sheet of 10/01/15 documented an unstageable pressure ulcer to the	F 314	resolution, formal appeal procedure, and/or other administrative or legal proceedings. F314 1. Resident #102 has a plan of care that was initiated on 9-22-15 by the treatment nurse that includes preventive skin integrity interventions to include the reporting of skin abnormalities and/or changes upon identification to the charge nurse by the nursing assistants. 2. A 100% audit of all residents in the facility was completed on 10-22-15 by the licensed nurses to ensure that all other residents at risk for skin breakdown have been evaluated with plan of care revisions and additions as necessary. All nursing staff to include Nursing Assistant #1, have been in-serviced by the DON on 10-22-15 to report all skin issues to the primary nurse as soon as identified. All newly hired nursing staff will receive training on the reporting of skin abnormalities and/or changes procedure during orientation by the Staff Facilitator. The primary nurse is responsible for completion of the skin referral in the residents' electronic medical record. Upon receipt of the skin referral, a notification alert is generated for the treatment nurse. The treatment nurse will evaluate the skin abnormality and/or change for the implementation of preventive interventions and/or treatment as ordered by residents' attending physicians.	

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F 314	Continued From page 2 left heel that measured 4.2 centimeters by 3.2 centimeters. A wound consult note of 10/07/15 documented Resident #102 had an unstageable deep tissue injury that measured 3 centimeters by 4 centimeters. The plan was to apply betadine daily. The "Preventative Interventions" form of 10/07/15 noted to turn and reposition Resident #102 and use of a specialized boot. A physician's telephone order of 10/09/15 documented to provide Impact AR (supplement) 120 milliliters four times daily for 30 days to aid in healing. It noted to discontinue Resource. A wound consult note of 10/12/15 indicated Resident #102 was seen. It was noted that the resident presented with an unstageable deep tissue injury of the left heel of at least 31 days duration. It measured 2.8 centimeters by 3.6 centimeters. The plan was to continue betadine daily. Resident #102's care plan, last revised on 10/14/15, identified a problem of being at risk for skin breakdown with actual skin breakdown to the left heel. Interventions included turn and reposition frequently, inspect skin and notify nurse of any abnormal changes. Wound care was observed on 10/21/15 at 3:50 PM. The treatment nurse washed her hands and donned a clean pair of gloves. She removed the blue specialized boot from her left foot. She removed her sock. She removed the old foam dressing from Resident #102's left heel. The	F 314	3. To ensure that all skin issues are reported to the primary nurse as soon as identified, skin assessments will be completed by the licensed nurse on each resident to include Resident #102 using a skin audit tool during showers 2x weekly x4 weeks, then 1x weekly x8 weeks, then 1x monthly x3 months. Upon the identification of any potential concern, the licensed nurse and/or staff facilitator will provide re-education to the involved personnel on the procedure for reporting skin abnormalities and/or changes to the primary nurse. 4. To ensure that the plan of correction is sustained on an ongoing basis, the skin audit will be reviewed by the DON or administrative nurse 1x week x4 weeks, then monthly x5 months to ensure that skin assessments are being completed and that corrective action is taken if applicable. The results of the audit tracking tool will be compiled by the DON and forwarded for review by the Executive QI committee quarterly x6 months for the identification of potential trends. The Executive QI committee consists of the Medical Director, Administrator, DON, QI Nurse, Staff Facilitator, Resource Nurse, MDS Nurse, Medical Records and Admissions Coordinator. Follow up action will be implemented as deemed necessary and also to determine the need and/or frequency for continued monitoring.	

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wound was located on the outer left aspect of her left heel with 100% black intact skin noted and was approximately 4 centimeters by 3 centimeters in size. The treatment nurse painted the area with betadine and placed a clean foam dressing to the heel. The treatment nurse reported that treatment was started as soon as the area was reported to her. She stated the area was black upon her first assessment.

Nurse Aide #1 (NA #1) was interviewed on 10/22/15 at 9:00 AM. She reported being Resident #102's regular assigned aide. She stated she was aware of the area on the left heel when she went on vacation last month but didn't report it to any one because she thought the nurse was already aware. She reported Resident #102 had dry skin to her feet but didn't like for her to apply lotion to her feet. NA #1 commented the left heel was reddened and had some black colored skin present. She stated upon her return from vacation, NA #2 had asked her about the wound and she told her she had it before she went on vacation. NA #1 stated she was supposed to report any changes in the resident's skin which included redness that didn't resolve to the nurses. She also commented that she was not the only aide who had provided care for Resident #102.

Nurse #1 was interviewed on 10/22/15 at 9:20 AM. After reading her note of 09/22/15, she stated she couldn't remember which aide had reported the area to Resident #102's heel because her regular nurse aide was on vacation that week. She reported the aide told her that the wound had been there for a while but didn't specify how long. Nurse #1 stated Resident #102 was wearing bunny boots when she went to

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assess her left heel. Nurse #1 stated there was hard eschar noted when she observed the wound. She stated the treatment nurse had been notified that day as well and had provided treatment. Nurse #1 stated she depended upon the nurse aides to report any changes in a resident's skin and wondered why it hadn't been reported sooner since different staff members had provided care for her.

NA #2 was interviewed on 10/22/15 at 9:45 AM. She stated she was the restorative aide who worked with Resident #102 in the restorative program for passive range of motion exercises. She stated she discovered the wound to her left heel when she started doing ankle exercises on 09/22/15. She stated usually Resident #102 was wearing socks but that day she was not and she was able to visualize her skin. NA #2 stated the area was dark black. NA #2 stated she immediately went to Nurse #1 and reported the area because she didn't know if it had been reported or not and wanted to make sure someone was aware of it. She also stated she told the treatment nurse about the area as well. NA #2 stated when NA #1 came back from vacation she asked her about the area and NA #1 told her she was aware of the area.

The Director of Nurses (DON) was interviewed on 10/22/15 at 11:00 AM. She stated there was no formal skin check system in place at the present time. She stated nurse aides were expected to report any change of any kind in a resident's skin to the nurses. She commented that the aides were the ones providing the care and were to inspect the resident's skin every time they provided care. The DON stated the wound on

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F 314	Continued From page 5 Resident #102's heel should have been reported as soon as it was noticed. She also stated it was the aide's responsibility to report a change even if it had already been reported by someone else. NA #3 was interviewed on 10/22/15 at 2:30 PM. She stated she had worked with Resident #102 while NA #1 was on vacation. She reported the resident needed total care from staff but couldn't remember the appearance of her skin when she worked with her. She commented she was supposed to report any open areas, redness, bruises or any changes in the resident's skin to the nurse. .	F 314		