STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	C 05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH AND REHABILITATION CENTER	1510 HEBRON STREET HENDERSONVILLE, NC 28739

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F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide a comprehensive wound assessment, initiate treatment, and monitor two pressure ulcers identified on admission, failed to initiate interventions to prevent further skin break down, and failed to provide nutrition interventions as recommended by a registered dietician (RD) to promote wound healing for 1 of 3 sampled residents reviewed for pressure ulcers (Resident #2). Findings included: Resident #2 was admitted to the facility on 4/13/17 and discharged to home on 4/25/17 with diagnoses that included cerebral infarction, hypertension, and chronic obstructive pulmonary	F 314	How will corrective action be accomplished for those residents found to have been affected by the deficient practice: Resident #2 was discharged on 4/25/17 and did not return to the facility. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by this deficient practice. Corrective Actions include: All residents will have a head to toe skin	6/22/17

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

Electronically Signed | 06/12/2017

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F 314	Continued From page 1 disease. A record review revealed a FL2 (a form which determines need for skilled nursing care placement) dated 4/13/17 which indicated Resident #1 had a 2 cm (centimeter) right ischial wound. A record review revealed an admission nursing assessment dated 4/13/17 which indicated Resident #2 had a stage one pressure ulcer to the left heel and a stage one pressure ulcer to the coccyx. The admission nursing assessment did not indicate measurements for the pressure ulcers or treatments to the areas. A Braden scale for predicting pressure ulcers dated 4/13/17 revealed a score of 15 which indicated Resident #2 was at risk for developing pressure ulcers. A nursing initial care plan dated 4/13/17 revealed Resident #2 had a pressure ulcer and care plan goal was that the wound would show signs of healing with area decreasing in overall size and depth by next review. The care plan interventions included to provide wound care, observe wound healing, and to notify the Medical Doctor (MD) of changes in the wound or emerging wounds. A record review revealed a nursing note dated 4/14/17 which indicated Resident #2 continued to complain of pain to 2 cm wound on right ischium. A lab dated 4/17/17 indicated a low Albumin level of 1.1 (normal range 3.2 to 5.5) and a low total protein level of 4.7 (normal range 6.7 to 8.2). A nutrition therapy recommendation by the RD	F 314	assessment performed by a licensed nurse on or before 6/16/17 to identify any skin alterations that may not have been previously identified. In-services to licensed Nursing staff will be conducted by the Director of Nursing Services (DNS) or designee on or before 6/21/17 to educate on correctly performing a head to toe skin assessment upon admission and the need to measure, describe and document skin alterations as necessary. Education will include notification to the physician for any new orders and treatments which will then be entered into Point Click Care (PCC) to proceed on the TAR. A review of the facility Skin Management program will be reviewed by the DNS with licensed Nursing staff on or before 6/21/17 and will include newly admitted residents, skin assessments, treatments, head to toe skin assessments, Braden Scale for Predicting Pressure Sore Risk, measurement of pressure ulcers and pressure reduction and prevention. Care plan goals for residents at high risk for alteration in skin integrity and actual alteration in skin integrity will be reviewed weekly by the Interdisciplinary Team (IDT) during the weekly wound care meetings to assure accuracy and to update interventions as necessary. The Registered Dietician□s (RD) recommendations to physicians will be signed and orders obtained in a timely	

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F 314	Continued From page 2 dated 4/19/17 indicated Prostat (a protein supplement) 30 milliliters (ml) everyday by mouth for wound healing. MD orders for April 2017 for Resident #2 did not reveal an order for Prostat. A head to toe skin check for Resident #2 dated 4/19/17 reveled an existing shear to left buttock fold 1.5 x 1 cm. A weekly pressure ulcer record dated 4/21/17 revealed a 5 x 4 cm pressure ulcer, suspected deep tissue injury (DTI) to left heel that was new and acquired at facility. A weekly pressure ulcer record dated 4/21/17 revealed a 4 x 3 cm pressure ulcer, suspected deep tissue injury (DTI) to right heel that was new and acquired at facility. A treatment sheet for Resident #2 dated April 2017 indicated to clean the left lower buttock fold with normal saline and cover with foam dressing every day shift. The treatment was signed as completed on days 4/20/17 to 4/25/17. A treatment sheet for Resident #2 dated April 2017 indicated to apply skin prep to bilateral heels every shift. The treatment was signed as completed on days 4/20/17 to 4/23/17. A treatment sheet for Resident #2 dated April 2017 indicated to apply skin prep to bilateral heels and toes every shift. The treatment was signed as completed on days 4/23/17 to 4/25/17. A treatment sheet for Resident #2 dated April 2017 indicated for heel protectors on while in bed.	F 314	manner. Licensed nursing staff will be in-serviced by the Director of Nursing Services (DNS) or designee on or before 6/21/17 related to performing 24-hour chart reviews to ensure that orders are not missed. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: The DNS or designee will ensure that all new admission charts are brought to the next morning meeting and assessments will be reviewed by the IDT team to identify if the new resident is at elevated risk for skin breakdown. If so, preventative measures will be put into place and added to the care plan to address skin breakdown. In addition, care plans will be reviewed and treatment orders checked for accuracy and confirmation that the order is on the TAR. Unit Managers/designees will monitor the Weekly Skin Assessments and ensure that they are performed on the designated date. The Unit Managers/designees will also monitor the TARS and check dressings to ensure they are being applied per physician orders. The DNS or designee will also monitor that the 11-7 shift is performing 24-hour Chart reviews to ensure that all physicians orders have been entered into PCC to show up on the MAR/TAR.	

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F 314	Continued From page 3 The treatment was signed as completed on 4/22/17 to 4/25/17. A discharge Minimum Data Set (MDS) assessment dated 4/25/17 revealed Resident #2 had one stage two pressure ulcer on admission. The MDS also indicated Resident #2 had two unstageable DTI pressure ulcers with one that was present on admission. On 5/24/17 at 2:22 PM an interview with Nurse #2 who was the wound nurse, stated Resident #2 had an abrasion on her left gluteal fold on admission on 4/13/17 and a treatment was started on 4/19/17 to clean with normal saline and apply a foam dressing. Nurse #2 also stated that Resident #2 had "mushy heels" that were DTI and skin prep was applied daily from 4/22/17 until discharge. Nurse #2 stated the left heel DTI was a new area acquired in the facility and the right heel was found on admission. Nurse #2 stated she did not know why there was not a treatment order for Resident 2 completed for the left buttock and right heel on admission. Nurse #2 stated if a resident was admitted with a pressure sore or skin issue, the primary nurse would identify the area, and follow the recommended instructions on the skin and wound care guidelines. Nurse #2 also stated the admission nurse was supposed to use their own nursing judgment or call the doctor for treatment orders. Nurse #2 further stated the facility should have caught that Resident #2 did not have a treatment order for the pressure ulcers found on admission. On 5/24/17 at 3:29 PM Nurse #1 revealed that on admission Resident #2 had an area on the left gluteal fold that was pressure related and a pressure ulcer to the right heel. Nurse #1 stated	F 314	The facility has retained a consulting Wound Care physician who will also be making regular rounds to evaluate and treat all patients identified with any type of wounds . How will the facility monitor its performance to make sure that solutions are sustained: The DNS or designee will ensure that admission assessments are accurate and that treatment orders are entered into PCC to reflect on the TAR. Upon admission, residents will have a Braden Score assessment to identify if they are at high risk for skin breakdown. If they flag for high risk then the IDT will look at interventions to put into place to prevent breakdown. The DNS or designee will ensure that any residents with a pressure area will be put on the agenda for the Wound Care Meeting regardless of stage or open wound. The DNS or designee will monitor the completion of the Weekly Skin Assessments to identify any new areas of breakdown or current areas that are worsening. To ensure ongoing compliance, the DNS or designee will audit the completion of each of the above described interventions using an audit tool weekly for four (4)	

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F 314	Continued From page 4 she was not sure if a treatment was completed to the areas and if so the treatments were completed on first shift. Nurse #1 also stated she did not perform any treatments to the areas that she could recall. Nurse #1 indicated she did not recall writing any orders for the pressure areas for Resident #2 on admission. Nurse #1 went on to say the wound nurse would be notified of the skin areas and then the wound nurse was supposed to round with the nurse practitioner and get a treatment order. Nurse #1 stated she did not personally notify the wound nurse of the pressure areas found on admit for Resident #2. Nurse #1 indicated she would have expected for a treatment to have been completed for Resident #2 to prevent the areas from worsening. On 5/25/17 at 9:45 AM during an interview the RD stated Resident #2 on admission had a stage one pressure ulcer on the left heel and a stage two pressure wound on the gluteal area. The RD also stated Resident #2 had a low albumin level of 1.1. The RD indicated Resident #2 was agreeable to receiving prostat for wound healing. The RD indicated she would have expected her recommendation for prostat for Resident #2 to have been followed thru. On 5/25/17 at 10:01 AM an interview with the MD stated the facility should have identified Resident's #2 pressure wounds and ordered treatments on admission. The MD stated he expected for the RD recommendations to be followed and Resident #2 should have received the prostat because of the wounds and the low Albumin level. During an interview on 5/25/17 at 10:50 AM the Assistant Director of Nursing (ADON) stated if a	F 314	weeks and monthly thereafter for two (2) months. The results of these audits will be reviewed at the facility,□s QAPI meeting and corrective action taken as necessary.	

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resident was admitted to the facility with a skin issue or pressure ulcer, the admission nurse was supposed to complete the skin assessment and notify the wound nurse by leaving her a note in the wound book or leaving her a phone message. The ADON also stated if the wound nurse was not available then the nurse was supposed to call the doctor and get treatment orders. The ADON indicated she remembered Resident #2 to have an excoriated area on her buttocks. The ADON stated she did not remember an area on Resident's #2 heel. The ADON stated her expectations were for the admission nurse to have notified the wound nurse of the pressure areas for Resident #2 and started treatments to the areas. The ADON went on to say there had been a problem with the RD recommendations getting missed and now the new RD had been instructed to give the recommendations to the ADON. The ADON indicated she did not know that the RD had recommended prostat for Resident #2 because the previous Director of Nursing had handled the RD recommendations.

During an interview on 5/25/17 at 11:20 AM the Administrator stated he expected for the wounds for Resident #2 to be assessed and treated on admission and for the dietary recommendations to be followed.