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	345197	A. BUILDING _____ B. WING _____	C 07/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	237 TRYON ROAD RUTHERFORDTON, NC 28139

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F 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted from 7/21/20 through 7/24/20 Event ID# 9ZQY11. There were three allegations investigated and one was substantiated. Event ID# 9ZQY11.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		8/19/20

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

Electronically Signed | 08/14/2020

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F 656	Continued From page 1 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a care plan for the prevention, and care of a resident who was high risk and developed a pressure ulcer of the sacrum for 1 of 2 residents (Resident #1). The findings Included: Resident #1 was admitted to the facility on 6/15/20 with a diagnosis that included neurological injury, muscle weakness, lack of coordination, and muscle spasms. The admission Minimum Data Set (MDS) assessment dated 6/22/20 revealed Resident #1 was at risk of receiving pressures ulcers and required extensive assistance for bed mobility. The MDS assessment further revealed Resident #1 was cognitively intact. Review of Resident #1 medical record reviewed no care plan or interventions for pressure ulcers. Review of a physician order dated 7/1/20 revealed a referral for a wound consult. The physician ordered for the wound to be cleansed with wound cleaner, apply collagen sheet, and	F 656	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Licensed nurse initiated a Pressure ulcer care plan for Resident #1 on 7/18/20 and revised on 7/21, 7/28 and 8/04/2020. Address how the facility will identify other residents having the potential to be affected by the same deficient practice The MDS coordinators and Licensed nurses completed an audit on 8/03/20, of current residents with wounds, to validate that residents identified had a pressure ulcer care plan implemented. All residents identified had a care plan initiated for pressure ulcers. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;	

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F 656	Continued From page 2 cover with foam dressing. This was to be implemented daily every Monday, Wednesday, and Friday. Review of Resident #1 consultation with the wound doctor dated 7/6/20 revealed Resident #1 had an unstageable wound to the sacrum and a shear wound to the right buttock. Interview with the MDS Coordinator #1 on 7/21/20 at 3:05 pm revealed a comprehensive care plan was to be developed within 8 days of admission. MDS Coordinator #1 revealed a comprehensive care plan should have been implemented at the time the resident developed the wound and should have been updated when the resident developed an infection. Interview with the Assistance Director of Nursing (ADON) on 7/21/20 at 3:22 pm revealed Resident #1 had a wound to his sacrum. The ADON indicated she did not document her initial observation of Resident #1's wound. The ADON revealed that a care plan should have been implemented when the area of pressure was identified. Interview with the Director of Nursing (DON) on 7/21/20 at 2:44 pm revealed that there was a dark spot on Resident #1 at the time of admission on 6/15/20. The DON indicated when a resident had skin break down, a care plan should be implemented. The DON revealed that she did not know that there was not a care plan for Resident #1. The care plan should have been developed at the time the wound was identified.	F 656	The Regional Clinical Director provided education for the Director of Nursing on 7/24/2020, regarding implementation and revision of pressure ulcer care plans. The Director of Nursing (DON) provided education for the MDS nurses and wound care nurse on 8/3/20, regarding implementation and revision of pressure ulcer care plans. Beginning 8/19/20, upon admission to the facility, the licensed nurse will assess the resident for pressure ulcer risk, using the Braden scale, and will implement a pressure ulcer care plan specific to the residents needs and identified skin issue. Beginning 8/19/20, the MDS nurse and/or the wound care nurse will review the pressure ulcer care plan at least quarterly, annually and with any significant change and update as necessary to reflect the skin needs/issues for the resident. Beginning 8/19/20, the wound care nurse will update pressure ulcer care plan weekly for residents identified with actual skin/wound issues, to include treatment changes, wound changes and new interventions as necessary. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; Beginning 8/19/20, the DON and/or the ADON will audit 5 residents with pressure ulcers weekly for 4 weeks then 10	

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F 656	Continued From page 3	F 656	residents monthly for 2 months, to validate that the resident has a pressure ulcer care plan and the care plan is updated weekly and as needed. Beginning 8/19/20, the DON or ADON will review the audits monthly to identify any patterns/trends and will adjust the plan as necessary to maintain compliance. Indicate dates when corrective action will be completed; August 19, 2020	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(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 record review, staff interviews, and physician interviews, the facility failed to provide care according to recommendations to promote healing of an in-house acquired sacral wound for 1 of 2 residents (Resident #1) that resulted in an	F 686	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;	8/19/20

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F 686	Continued From page 4 infection. The findings included: Resident #1 was admitted to the facility on 6/15/20 with diagnosis that included unspecified injury at unspecified level of neurological injury. Review of the admission nursing assessment dated 6/15/20 revealed Resident #1 required total dependence for bed mobility, and transfers. Resident #1's skin was warm, dry, and intact. The Braden Scale dated 6/15/20 for Resident #1 revealed a score of 15, which indicated he was at risk for skin breakdown. The Admission Minimum Data Set (MDS) dated 6/22/20 revealed Resident #1 was cognitively intact, required extensive assistance of 2 staff persons for bed mobility and had no areas of skin breakdown. Review of physician order dated 7/1/20 revealed a wound care consult for Resident #1. This physician order was the first documentation in Resident #1's record related to the wound. Continued review of the physician orders dated 7/1/20 revealed wound care orders for Resident #1's sacral wound that stated cleanse area with wound cleanser, apply collagen sheet, cover with foam dressing every day shift every Monday, Wednesday, and Friday. Review of Resident #1's weekly skin check dated 7/2/20 indicated the resident had discoloration to the middle of his sacrum. The skin check further revealed the Director of Nursing (DON) was	F 686	Resident #1 was seen by wound care physician on 8.10.2020, no new orders was given. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The licensed nurses completed a skin audit on current facility residents on 7/31/20, to identify residents with skin/wound issues, and validate that treatment orders are in place and current. All residents identified with skin/wound issues had current treatment orders in place and initiated. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Beginning 8/19/20, the licensed nurse (wound nurse) making rounds with wound physician will input new/changed orders into the electronic medical record at bedside when the wound physician makes treatment changes. The orders will go directly to the Treatment Administration Record to be implemented on the date specified by the physician. The Regional Clinical Director provided education for the Director of Nursing on 7/24/20, regarding the implementation of new and/or changes in treatment orders to include inputting the orders into the electronic medical record at bedside and will be implemented on the date specified by the physician.	

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F 686	Continued From page 5 notified and no dressing present upon the observation. Review of Resident #1's medical record revealed no care plan or interventions for pressure ulcers. A review of the Wound Care Physician consult dated 7/6/20 revealed a debridement was completed to Resident #1's sacral wound. The Wound Care Physician indicated Resident #1 was currently on a Group 1 mattress (mattress, pressure pad, overlay). The note continued that Resident #1 had an unstageable pressure ulcer to the sacrum and shearing to the right buttock. Recommendations for treatment stated; wound care to sacrum, cleanse with wound cleanser, pat dry, apply calcium alginate with silver, cover with gauze dressing, apply skin prep around area every day shift. Other recommendations included off-load wound, Group 2 mattress (pressure relieving mattress), limit sitting to 30 minutes, and reposition per facility protocol. His documentation stated Resident #1's care was discussed with the Director of Nursing (DON) and an assigned nurse (not named). Review of physician order dated 7/11/20 stated wound care to sacrum, cleanse with wound cleanser, pat dry, apply calcium alginate with silver, cover with a gauze dressing, and apply skin prep around the area every day shift. Review of physician order dated 7/11/20 revealed Resident #1 was to receive Levaquin 500 milligrams (mg) for a wound infection for 14 days. An interview on 7/21/20 at 1:45pm with the Wound Care Nurse revealed she was notified of any wound development by nursing staff. In the	F 686	The Director of Nursing (DON) educated the wound nurse and the wound physician on 7/24/20, regarding the implementation of new and/or change in treatment orders to include inputting the order into the electronic medical record at bedside and will be implemented on the date specified by the physician. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; Beginning 8/19/20, the DON and/or the ADON will review Physician wound notes weekly for 3 months and will validate that new orders were input into the electronic medical record and the new or changed order was implemented. Beginning 8/20/20, the DON or ADON will review the monitors monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. Beginning 8/19/20, the DON or ADON will review the plan during the monthly QAPI and will continue the audits at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; August 19, 2020	

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F 686	Continued From page 6	F 686		

instance she was not available, unit coordinators completed wound care. The Wound Care Nurse stated she recalled being notified that Resident #1 had developed a wound 3 weeks into admission. She further revealed that Resident #1 was admitted to the facility during her absence and the resident was documented as having no pressure areas upon admission. Observation of Resident #1's sacrum on 7/1/20 revealed a closed necrotic area and a wound consult was written.

The Assistant Director of Nursing (ADON) was interviewed on 7/21/20 at 3:21pm and it was reported to her by a nursing assistant (not named) on 7/2/20 that Resident #1 had a wound on his bottom. She stated the wound to his bottom appeared to be scar tissue. Physical therapy was notified, and a wedge cushion, bedrest, and repositioning was implemented every 2 hours. A wound consult was further ensured. The ADON stated the Wound Care Physician saw Resident #1 on 7/6/20. Resident #1's sacral wound was necrotic was debrided. The ADON revealed she had not documented any wound treatment provided by the Wound Care Physician. She stated she should have documented the onset of the wound and interventions recommended.

A continued interview with the Wound Care Nurse on 7/22/20 at 1:08 pm revealed she was notified of Resident #1's sacral wound by the ADON on 7/1/20. Her observation of Resident #1's sacrum revealed a small area with necrotic tissue. The Wound Care Nurse stated wound measurements should have been documented in the nursing progress notes, but she was unaware if she had documented Resident #1's wound status. The

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F 686	Continued From page 7	F 686		

Wound Care Nurse stated she implemented a wound consult and further included preventative measures on 7/1/20. The preventative measures put into place were cleanse area with wound cleanser, apply collagen sheet, cover with foam dressing every day shift every Monday, Wednesday, and Friday. The Wound Care Nurse indicated she was not present to round with the Wound Care Physician on 7/6/20. She stated the nurse who made rounds with the Wound Doctor should have ensured wound care orders were communicated.

On 7/22/20 at 2:18pm the DON was interviewed which revealed she was present when the Wound Care Physician debrided Resident #1's wound on 7/6/20. The DON stated the Wound Care Physician's recommendations were sent through an electronic portal. The Wound Care Nurse would receive the recommendations through the portal and process any orders. The Wound Care Nurse would provide recommendations to the Primary Care Physician (PCP) or Family Nurse Practitioner for approval. Resident #1's new wound care orders were put into place on Saturday, 7/11/20.

An interview on 7/23/20 at 10:22am with the Wound Care Physician revealed Resident #1 had a large necrotic area which required extensive debridement. The Wound Care Physician revealed he completed Resident #1's debridement and was followed by the ADON. The Wound Care Physician further stated the DON was present as well. Upon exiting the facility, the Wound Care Physician stated he provided the facility with recommendations for care and treatment and the consult was available to the facility via an electronic portal following his

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F 686	Continued From page 8	F 686		

assessment. He stated the facility should have put recommendations into place on 7/6/20 following Resident #1's debridement to promote healing. The Wound Care Physician stated following Resident #1's debridement he had placed recommended wound dressings to the resident's sacrum to include alginate with silver.

On 7/23/20 at 10:55am an interview with the Primary Care Physician (PCP) revealed Resident #1 did not have any wounds upon admission to the facility. He stated recommendations from the Wound Care Physician would be available to the facility via an electronic portal. The PCP revealed the facility should document the resident's wound status and implement recommendations. The PCP stated he was unsure if it was a delay in care or whether it was a delay with receiving wound care recommendations. The PCP stated the facility dropped the ball on documenting Resident #1's wound status and ensuring recommendations were followed. The resident's sacral wound did not require an antibiotic until 7/11/20.

Continued interview on 7/24/20 at 9:20am with the Wound Care Physician revealed the continued use of the collagen dressing as ordered by the Wound Care Nurse would have been okay for use but would have been contraindicated. The Wound Care Physician indicated the use of the calcium alginate he recommended on 7/6/20 would have served as moisture to the wound bed and contained microbial properties. Collagen would not manage the moisture without the use of the calcium alginate. After Resident #1's debridement the Wound Care Physician stated his 7/6/20 recommendations would have been his

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F 686	Continued From page 9 preference for wound healing.	F 686		