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	345126	A. BUILDING _____ B. WING _____	C 01/14/2021

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MOUNT OLIVE CENTER	228 SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

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F 000	INITIAL COMMENTS The survey team entered the facility on 1/11/2021 to conduct an unannounced complaint investigation and on-site follow up. Additional information was obtained offsite on 1/12/2021 and 1/13/2021. Therefore, the exit date was 1/14/2021. 2 of the 15 complaint allegations were substantiated and resulted in deficiencies F557 and F580. Event ID# 66W111.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on record review, observations and resident and staff interviews, the facility failed to provide a resident 's personal belongings for eight days after she returned to her room for 1 of 1 sampled residents reviewed for the right to retain and use of personal possessions. (Resident #1) The findings included: The annual Minimum Data Set (MDS) assessment dated 9/14/2020 revealed Resident #1 was cognitively intact, performed all activities of daily living independently and was continent of urine and bowel.	F 557	Complaint Survey 01/14/21 POC F557 (D) " All personal items have been returned to Resident #1 and a new personal inventory completed. " There is potential for any resident experiencing a room change to have some personal items not moved at the time of transfer. All residents who have had a room change in the last 30 days have been interviewed to determine if all belongings have been returned. If the resident is unable to be interviewed, the	2/2/21

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

Electronically Signed | 01/27/2021

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F 557	Continued From page 1 On 12/22/2020, Resident #1 fell and was sent to the emergency room for an evaluation. On 12/22/2020, Resident #1's responsible party was informed of the Bed Hold Notice Policy and agreed to hold Resident #1's Room #131 for three days. On 12/23/2020, Resident #1 was re-admitted to the facility 's quarantine area, Room #109. On 12/28/2020, the census revealed the resident was moved to Room #120 on the quarantine unit. On 1/5/2021, Resident #1 was moved from the quarantine unit, Room #120, back to her Room #131. On 1/11/2021 at 1:51pm, Resident #1 was observed lying in her bed wearing a facility gown. A walker was observed leaning against the wall between the bedside table and closet. The closet door was observed half opened with no personal clothing and a pack of adult briefs at the bottom of the closet. The bathroom was observed without a raised toilet seat or personal items, the drawers of the bedside table were observed empty with no personal items and only a small clock was observed on the wall. On 1/11/2021 at 1:51pm in an interview with Resident #1, she stated all her belongings were packed up and located on Station 3 in the old fellowship hall. She stated the physical therapist talked to the social worker about her not having her belongings. As she pulled at the sleeve of the facility 's gown with a disguised look, she stated, " I ' m having to wear this old thing. They have not	F 557	residents inventory sheets were reviewed to ensure all belongings were returned. " We have reviewed the room change process and are taking the following actions to avoid recurrence of personal possessions not transferring with the resident when room changes occur: 1. Staff re-educated on the requirements of F557 2. Eliminate the involvement of personnel not essential in the room change process. When a room change decision is made and the resident is made aware of why and when a room change is occurring, housekeeping staff (accountable for moving resident belongings) will be informed directly; this will minimize the opportunity for error by coordinating the moving of possessions with the resident. 3. The C.N.A. receiving the new resident will document on the back of the residents□ ADL sheet when personal possessions are received on the unit. " Following room changes compliance will be monitored by each Unit Manager; any negative variance from the plan of correction will be corrected at the time of observation. The Social Worker will conduct a 100% audit times four (4) weeks, a 50% audit times four (4) weeks and a 25% audit times four (4) weeks or until sustained compliance is achieved. The Social Worker will present a monthly audit outcome report to the QAPI Committee accountable for monitoring the process and to determine if the corrective action has been effective in achieving resolution.	

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brought me my clothes." She stated the raised toilet seat was not in the bathroom and she was wearing diapers that were itching her to death. She stated her recliner and refrigerator were still in storage also and stated "I kept me something to eat and orange juice in the refrigerator, when it was here, in case my blood sugar was dropping." Resident #1 further noted how bare her room and walls were without any of her pictures and belongings.

On 1/13/2021 at 8:57am in a phone interview with the Social Worker, she stated after Resident #1 went to the hospital and stayed overnight she was re-admitted to the quarantine unit, and her personal belongings were boxed up and placed in storage. She stated housekeeping should have been Resident #1's personal belongings on the day she was moved from the quarantine unit, Room #120. When the Social Worker was informed on 1/11/2021 Resident #1's room was observed with no personal belongings, she stated she was unaware Resident #1's personal belongings were not in her room and would get the personal belongings moved into her room today. The Social Worker further stated it was a human error why the personal belongings had not been returned to Resident #1's Room #131.

On 1/13/21 at 12:05pm in a phone interview with the Environmental Services Assistant Manager, she stated housekeeping was responsible for moving the resident and their belongings from one room to another room, and the Social Worker or the Director of Nursing notified the housekeeping department with the resident 's name and room number on the schedule to move daily. She stated personal belongings were packed and moved with the resident. She stated

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Resident #1 had a lot of personal belongings that were locked up while she was on the quarantine unit, but the nursing staff could get anything she needed. When she was informed Resident #1 was moved from Room #120 to Room #131 without her personal belongings for eight days, she stated the Plant Operations Manager was out of work when Resident #1 was moved, and housekeeping did not have a key to the locked storage area. She stated the housekeeping department was informed today to move Resident #1's personal belongings to Room #131, and a floor tech was assigned the task.

On 1/13/21 at 12:42 pm in a phone interview with the Director of Nursing (DON), she stated Resident #1 had a lot of personal belongings and while on the quarantine unit she should have had some clothes and personal items that should have been moved with Resident #1 to Room #131. When informed the resident had no personal belongings in Room #131, she stated she didn't know why and stated usually Resident #1 informed the staff of her needs. She further stated the Social Worker coordinated resident room assignments and communicated with the housekeeping department and maintenance when moving the resident and their personal belongings.

On 1/13/21 at 3:24pm in a phone interview with Nurse Aide (NA) #1, she stated Resident #1 preferred wearing her own personal clothes and usually had pictures and a lot of figurines in her room. She denied Resident #1 asking her for her personal belongings.

On 1/13/2021 at 3:14 pm in a phone interview with the Plant Operations Manager, he stated the

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housekeeping department packed and labeled resident 's personal belongings. He stated the housekeeping storage unit was full and started using a locked office two weeks ago to store resident 's personal belongings. He stated the housekeeping department did not have a key to the locked office, and housekeeping needed to see the Administrator, Director of Nursing, the assistant manager of Plant Operations or himself to unlock the office to obtain any personal belongings of the residents.

On 1/13/2021 at 3:58 pm in a phone interview with the Environmental Services Manager, he stated it was the housekeeping department 's responsibility to return resident 's personal belongings to their room when transferred from one room to another room. He stated the facility 's staff communicated through emails or conversation when and where residents were scheduled to move. He admitted seeing something about Resident #1 moving, but stated his assistant manager handled moving the residents. He stated the resident and their belongings were usually moved the same day. When informed Resident #1's room was observed with no personal belongings on 1/11/2021 and asked why, he stated, "I do not know." He further stated all of Resident #1's personal belonging were returned to Room #131 today.

On 1/13/2021 at 8:56 pm in a phone interview with Nurse #1, she stated she was unable to recall the exact date but stated Resident #1 asked for her personal belongings one of the days between 1/6/2021 and 1/8/2021 when she was assigned to Resident #1. She stated she called and informed the Social Worker who was

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F 557	Continued From page 5 to inform the housekeeping department. On 1/14/2021 at 10:16 am in a phone interview with the Administrator, she stated not all personal items were returned to the residents when on the quarantine unit, just the personal belongings needed for the two weeks, but when moved to a regular room, all of the resident 's personal belongings should be returned to the resident. When she was informed Resident #1 spent eight days without her personal belongings returned to Room #131 after moving from the quarantine unit, she stated that was a mistake on our part and stated the facility had experienced an increase in the rate of residents changing rooms due to COVID-19 recently.	F 557		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in	F 580		2/2/21

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F 580	Continued From page 6 §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, responsible party interview and staff interviews, the facility failed to notify the responsible person for Resident #2 of changes in the condition of the resident's left foot wound and the wound's treatment plan for 1 of 2 residents reviewed for notification of significant changes. (Resident #2) The findings included:	F 580	F580 (D) " Resident #1 discharged from the facility on 01/09/21. " Due to the various situations that occur requiring notifications to one or all of the following: residents, resident physician, POA or other designated resident responsible party, all residents have the potential to be affected by the	

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F 580	Continued From page 7 Resident #2 was admitted to the facility on 2/1/2019 and diagnoses included hypertension, peripheral vascular disease, diabetes mellitus, cerebral vascular accident with hemiplegia, right above the knee amputation and contractures to left elbow and hand. Resident #2's significant change Minimum Data Set (MDS) dated 4/18/2020 revealed he was assessed as severely cognitively impaired and required total assistance with all activities of daily living. The skin assessment noted the presence of no pressure or vascular ulcer. A nurse's note dated 6/13/2020 revealed Resident #2's skin check was performed, and no skin injury or wounds were noted. Physician #1's progress note dated 6/17/2020 revealed Resident #2 had a left heel wound that was worsening, and the wound was dressed by the nurse. Physician #1 orders dated 6/17/2020 revealed Resident #2 was ordered an x-ray of the left heel to rule out osteomyelitis and laboratory tests that included a complete blood count (CBC) and a sedimentation rate. Physician #1 orders dated 6/18/2020 revealed betadine-soaked gauze to the left heel wrapped in kerlix every shift and off load/floating the heel were ordered as treatments to the left heel wound. Resident #2's revised care plan dated 6/18/2020 for the risk of skin breakdown revealed he had an actual pressure ulcer to the left heel.	F 580	facility failing to provide notification of changes. Nursing Administration audited the charts of all current residents with wounds to ensure appropriate notifications have been completed and documented. " We have reviewed the policy and procedure regarding notifications and no changes are warranted at this time. 1. Licensed staff have been re-educated by the NPE on the notification requirements of F580. This education included the need to document on attempts of notification. 2. The Unit Managers will review resident changes during morning clinical meetings to ensure proper notifications have been made and documented; any negative variance from policy will be corrected at the time of observation with education and/or disciplinary action as appropriate. " The DON and ADON will conduct random audits to validate compliance with the notification process summarizing audit outcomes in a monthly report to the QAPI Committee. Six (6) random audits will be conducted on each unit daily times four (4) weeks, four (4) random audits will be conducted on each unit daily times four (4) weeks and two (2) random audits will be conducted on each unit times four (4) weeks or until the QAPI Committee has determined the correction action has been effective and sustained compliance has been achieved.	

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Interventions included to off load and float the left heel, provide wound treatment as ordered, observe for verbal and nonverbal signs of pain related to wound or wound treatment and medicate as ordered, use of a pressure redistribution surface on the bed, and consult the dietician as needed. A revision of the skin breakdown dated 7/14/2020 identified the left heel as a venous ulcer.

Nurse's notes dated 6/19/2020 revealed the physician had been notified of the radiology results of the left heel on 6/18/2020, and the physician and the responsible party were notified of the laboratory results.

Physician #2 progress note dated 7/10/2020 revealed a discolored arterial wound to the subcutaneous tissue of the left heel. She noted there were no signs of infection and the periwound was intact. The wound measured 11.5cm x 6cm x 0.5cm, and treatment consisted of painting the wound with betadine, allowing the betadine to dry and covering with kerlix daily.

The wound care note dated 7/15/2020 written by the Assistant Director of Nursing (ADON) revealed the left heel wound was deep, intact and measured 7.2centimeters (cm) x 6cm x 0.5cm. She documented the tissue was 90% necrotic tissue and 10% purplish in color, and the surrounding tissue and wound edges were healthy with no drainage or odor noted. She noted Physician #2 was notified and Physician #2 used telemedicine to visualize Resident #2's left heel wound.

A Physician #2 progress note dated 7/15/2020 revealed the left heel wound had changed from

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discoloration to a black cap with excessive necrotic tissue and had decreased in wound volume. The left heel wound measured 7.2cm x 6 cm x 0.5cm. Treatment was changed to betadine-soaked gauze covered with kerlix daily.

On 7/22/2020, Physician #2 ordered the left heel wound was to be cleansed with half strength Dakins and apply a betadine-soaked gauze wrapped in kerlix daily to the left heel.

A nurse's note dated 7/24/2020 revealed Physician #2 was notified of the results of the arterial doppler studies to the left extremity.

A Physician #2 progress note dated 8/5/2020 revealed the left heel wound was stable and recommended a vascular consult that was unavailable due to COVID-19.

The wound care note dated 8/19/2020 written by Nurse #2 revealed the left heel wound measured 6.4cm x 7cm x 0.5cm with a light serosanguineous odorless drainage. The left heel wound was documented 10% intact, 80% necrotic tissue and 10% granulation tissue with deep purple maroon tissue surrounding the wound and the edges of the wound calloused. Nurse #2 documented the left heel had changed from the previous week, was now unstable with drainage present, notification of the physician and receiving new orders.

A Physician #2 progress note dated 8/19/2020 revealed the left heel wound was deteriorating. The necrotic black cap was becoming unstable with a mild amount of seropurulent drainage noted. The granulation tissue was noted unhealthy, and the periwound was noted intact.

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Treatment was changed to 0.5% Dakins moist gauze covered with kerlix daily.

On 8/21/2020, Physician #1 ordered the wound to be cleansed with wound cleanser and apply half strength Dakins soaked gauze to the heel and wrap in kerlix.

The wound care note dated 8/26/2020 written by Nurse #2 revealed the left heel wound measured 7cm x 8cm x 0.5cm and was draining a moderate amount of serosanguineous drainage. Nurse #2 documented the heel cap was unstable with an odor present and a vascular consult or debridement was unavailable due to COVID-19. Nurse #2 further documented the left heel as 10% intact, 70% necrotic tissue and 20% granulation tissue with edges of the wound and the surrounding tissues healthy. Nurse #2 documented the physician was notified.

A Physician #2 progress note dated 8/26/2020 revealed the left heel wound was unstable with a necrotic black cap with moderate amount of seropurulent drainage that had a mild odor. Physician #2 recommended a vascular consult and debridement of the left heel wound but due to active COVID-19 cases in the facility providers were unable to enter the building or send Resident #2 out for the consult or debridement.

On 8/27/2020, Physician #2 ordered the left heel wound to be cleansed with wound cleanser, then apply full strength Dakins soak gauze to the wound bed and cover with an ABD pad and secured with kerlix and tape.

The wound care note dated 9/2/2020 written by Nurse #2 revealed the left heel wound measured

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7.3cm x 8cm x 0.5cm. Nurse #2 documented the heel cap was unstable and draining moderate amount of serosanguineous drainage that had a foul odor. She also documented the surrounding tissues were inflamed and indurated and the edges of the wound were edematous. She recorded she irrigated with 50 milliliters of 50% Dakin ' s under the heel cap and noted Resident #2 experienced pain to the area. She documented notification of the Physician #2, and Physician #2 recommended a vascular consult and debridement but due to active COVID-19 cases in the building neither were available.

A Physician #2 progress note dated 9/2/2020 revealed the left heel wound was unchanged with an unstable necrotic black cap that was draining a moderate amount of seropurulent drainage with a mild odor. She noted the periwound was intact.

On 9/2/2020, Physician #2 ordered to irrigate under the heel cap with full strength Dakin's and to cover the heel with a soaked gauze covered with foam and secured with Kerlix and tape daily.

A nurse's note dated 9/4/2020 written by the ADON revealed Physician #2 and the responsible party were notified of the change in the left heel wound.

A nurse's note dated 9/8/2020 revealed Resident #2 was transferred to the hospital for an evaluation due to hypernatremia and the Physician #1 and the responsible party were notified.

The hospital records dated 9/8/2020 revealed Resident #2 was sent to the Emergency Room (ER) for electrolyte imbalances. Family was at

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(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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bedside and stated they had not seen Resident #2 in the last 4 months. The ER physician's examination recorded an open, foul smelling wound to the left lateral foot/ankle. A left foot and ankle x-ray revealed gas in the soft tissue with overlying cellulitis and a large lateral foot/ankle wound.

On 1/11/2021 at 9:50am in a phone interview with the Responsible Party(RP) for Resident #2, the RP voiced a concern that the facility did not inform her that the resident's left heel wound had become worse and was in such bad condition. The RP stated the facility had not kept her informed about how the left foot wound was being treated.

On 1/12/2021 at 4:34 pm in a phone interview with Nurse #2, she stated the physician was notified as soon as changes to the left heel wound were identified and treatment was changed. She stated the left heel wound started having a lot of drainage and appeared to be debriding itself. Nurse #2 stated the responsible party was notified of the left heel wound and was aware the left heel wound was worsening. She stated she did not call the responsible party when treatments were changed and stated the responsible party was only notified when there was a significant change in the left heel wound. Nurse #2 stated that she did not call or inform the resident's responsible party of the changes in the resident's left heel wound.

On 1/13/2021 at 12:42 pm in a phone interview with the Director of Nursing (DON), she stated the responsible party was to be notified by the nurse or wound nurse of changes in a wound and treatments unless the family requested not to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345126	A. BUILDING _____ B. WING _____	C 01/14/2021

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called. She was unaware of Resident #2's responsible party requesting not to be notified and stated the responsible party should had been notified of the changes to the left heel wound and treatments.

On 1/14/2021 at 8:44 am in a phone interview with the ADON, she recalled providing care to the left heel wound and informing the responsible party of the left heel wound initially and days prior to Resident #2 going to the hospital. She stated when there was a change in the wound care it was entered into the order entry and if it was a significant change, the responsible party was notified. She denied the left heel wound changing from necrotic tissue to having a drainage with a foul odor as a significant change in the left heel wound that warranted the responsible party to be notified. She further stated the left heel wound had remained stable until the last week in the facility before going to the hospital for hypernatremia.

On 1/14/2021 at 10:16 am in a phone interview with the Administrator, she stated when a resident's status changes appropriate family members should be notified. The Administrator further stated the responsible party should have been notified of the changes in Resident #2's left heel wound and treatments.