

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/23/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345279	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ JAN 05 2012 B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/16/2011
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NAME OF PROVIDER OR SUPPLIER  HUNTER HILLS NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX BOX 8495 ROCKY MOUNT, NC 27804
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F 314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff and resident observations, resident/staff interviews, and record reviews the facility failed to use the most current pressure ulcer wound care order signed by the physician for 1 of 3 (#2) sampled residents with pressure ulcers.</p> <p>A review of Resident #2 's MDS on 12/15/11 at 5:30 pm indicated that the resident was hypertensive, had GERD, Renal insufficiency/renal failure, was a diabetic, had Hyperkalemia, had some dementia and depression and was on Hospice Care. Her Brief Interview for Mental Status (BIMS) score indicated that she was cognitively intact, but she was dependent on staff for bed mobility, transferring, dressing, bathing, and incontinent care. She needed one staff person for assistance with eating and was on O2. She was considered at risk for development of pressure ulcers and currently had 2 - Stage I pressure ulcers and 1 Stage II pressure ulcer.</p>	F 314	<p>Disclaimer Statement</p> <p>Hunter Hills Nursing and Rehabilitation Center acknowledges the receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance.</p> <p>Hunter Hills Nursing and Rehabilitaton's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute as admission that any deficiency is accurate. Further, Nash Rehabilitataion and Nursing Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle Bakker TITLE: NNA (X6) DATE: 12/28/11

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 314	<p>Continued From page 1</p> <p>On 12/15/11 at 12:57 pm an observation was made of the Resident #2 receiving wound care from Nurse (#3). Resident #2 was observed to be lying on her back in her bed was alert and oriented to surroundings and staff. Resident #2 gave permission for the observation of her wound care. The wound care nurse stated, " The resident has 3 pressure ulcers to her right heel/foot and the left foot/heel has a Bunny Boot on for pressure relief. The wound care nurse washed her hands, gloved and drew back the resident ' s blanket &amp; sheet. Resident #2 was observed to be wearing a pressure relieving bunny boot on her left foot. The resident ' s bandaged right foot/heel was resting on a small flat pillow. The wound care nurse removed the resident #2 ' s right foot bandage. Observations of 3 wounds were made with the wound care nurse. The nurse stated, and observation confirmed, " There are (3) pressure ulcers to the resident ' s right foot - one to the side (stage I), one to the bottom of the foot (Stage I), and one to the heel (Stage II). " The wound care nurse was observed cleaning the 3 pressure ulcers with wound cleanser then wiped the areas with 4x4 gauze pads. The nurse then removed her gloves, washed her hands and re-gloved. She then applied Xeroform impregnated gauze over the wound areas. She applied 4x4 gauze pads over the Xeroform and used a Kerlix wrap to secure the dressings. The wound care nurse stated, " The resident has a healed skin tear wound to her left lower leg, but it ' s no longer being treated. "</p> <p>On 12/15/2011 at 12:40 p.m. an initial review of resident #2 ' s medical record was made. The resident ' s medical record documented the resident to be on Hospice care due to the</p>	F 314	<p>The wound care order for resident # 2 was clarified by the physician on 12/15/2011</p> <p>A 100% audit of wound care orders will be completed by the Treatment Nurse to ensure the most current pressure ulcer wound care order is signed by the physician to match with current MD order on Treatment Administration Record by 1/2/2012. Any areas identified will be clarified by the Treatment Nurse and/or Nurse Manager and approved and signed by the attending physician.</p>	1/5/12	

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F 314	<p>Continued From page 2</p> <p>diagnosis of Failure to Thrive. The resident ' s MDS dated 11/11/2011 documented the resident to have a cognitive score of 14 (scores = 1-15 and 15 being the most cognitive), and having 1 Stage II pressure ulcer. The record also documented the resident as always being incontinent and was receiving Lasix 40mg PO QD.</p> <p>A review of the physician ' s orders concerning the wound care to resident #2 ' s right foot was made:</p> <ul style="list-style-type: none"> <li>- The initial order for the right foot wound care, dated 10/13/2011 was documented on a verbal order sheet: " Cleanse right heel with Normal Saline, Apply Santyl, 4x4, and wrap with Kerlix QD. "</li> <li>- The next order for the same wound was dated 11/30/2011 also documented on a verbal orders sheet revealed: " Late Entry - 11/02/2011, D/C Santyl Ointment to Right heel QD. "</li> <li>- The last and most current right foot wound care order was documented on resident #2 ' s monthly orders covering 12/01-31/2011 and was signed by the facility ' s PAC on 12/01/2011. This order documented: " Cleanse right heel with normal saline, swab with betadine, apply 4x4 gauze, and wrap with Kerlix. "</li> </ul> <p>A review of resident #2 ' s Treatment Administration Record (TAR) dated 12/01/2011 through 12/31/2011 was conducted with the facility ' s wound care nurse. The TAR documented - " Cleanse Right heel with wound care cleanser, apply Xeroform, 4x4, and Kerlix - QOD (Every Other Day). "</p>	F 314	<p>The Treatment Nurse was inserviced by the Administrator, (RN) on 12-29-2011 to ensure the most current pressure ulcer wound care orders are signed by the Physician to match the current pressure ulcer order on Treatment Administration record.</p> <p>Pressure ulcer wound care orders will be reviewed by the Treatment Nurse and/or Administrative Nurse to monitor that the most current wound order is signed by the Physician weekly x 4 weeks, then monthly x 3 months utilizing a QI tool that reflects the MD order and Treatment Administration Record match and Treatment Administration Record and MD order match. The results of the QI audits will be reviewed by the Administrator weekly x 4 weeks, then monthly x 3 months to ensure the facility's monitoring system is functioning appropriately.</p>		

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F 314	<p>Continued From page 3</p> <p>A review of resident 2 ' s care plan dated 08/22/2011 documented the following for the resident ' s pressure ulcer/wound care: Focus: Ulceration or interference with structural integrity of layers of skin caused by prolonged pressure R/T immobility; Goals: Current ulcer will not worsen through next review; Interventions: Staff to report any redness or open skin areas, ensure appropriate pressure relieving devices, Bunny boots to heels, Medications given as ordered, Turn and reposition while giving care.</p> <p>On 12/15/2011 at 12:50 p.m. a review of resident #2 ' s physician ' s progress notes for October and November 2011 were conducted. The progress notes documented:</p> <p>On 10/22/2011 - " Left heel with red firm area with 0 breakdown; Left heel pressure sore Grade 1"; On 11/01/2011 - " Left heel with redness and Epidermis with breakdown " ; On 11/17/2011 - " Heels bilateral with redness and early breakdown. "</p> <p>The physician ' s progress notes for 10/22/2011 and 11/01/2011 did not identify the right foot/heel wounds in the problem/diagnosis even though the initial orders for the resident ' s wound care were dated 10/13/2011. There was no progress note in the chart for the month of December 2011 for review.</p> <p>On 12/15/2011 at 1:05 p.m. staff interviews and second record reviews concerning resident #2 ' s physician ' s wound care orders and TAR</p>	F 314	The results of the QI audits will be reviewed in the Quality Improvement Committee meeting monthly with follow-up as deemed necessary for the identified concerns and to determine the need for and frequency of continued monitoring.		

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F 314	Continued From page 4 documentation were conducted with the facility staff members #3 and #4. Staff member #4, the hall nurse, acknowledged she was resident #2 's nurse and had also been her nurse previously during her shifts for the past several months. Staff member #4 was asked if she could find the physician ' s orders for resident #2 wound care as observed given by the wound care nurse. Staff member #4 reviewed the resident ' s medical record but could not find any physician ' s order in resident #2 ' s medical record or other areas (orders waiting signature, review, update files etc.) mirroring the resident ' s right foot wound care that was observed. Staff member #4 did find a documented wound care order that mirrored the observed wound care (using the Xeroform dressing) was for the resident ' s opposite extremity (left lower leg - a skin tear). The order documented - " Clean Skin Tear on the Lower Left Extremity with wound cleanser, apply wound gel Xeroform gauze, dry dressing with Kerlix. " When asked where the order to discontinue the wound care to the Left Lower Leg skin tear was located (as stated was discontinued by the wound care nurse during the wound care observation), Staff member #4 again reviewed resident #2 ' s medical record but could not find any order to stop the wound care for resident #2 ' s left lower leg.  During the same interview staff member #3 also reviewed resident #2 ' s medical record. She could not find any physician ' s order for the wound care as observed and also could not find the any physician ' s order to discontinue the wound care to resident #2 ' s lower left leg (skin tear). Staff member #3 acknowledged there should have been a written physician ' s order for	F 314			

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F 314	<p>Continued From page 5</p> <p>resident #2 ' s right foot/heel wound care and a second order to discontinue the left lower leg skin tear wound treatment.</p> <p>A third review of the resident ' s TAR was made with staff member #3. The TAR documented the initial, changes, and current wound care orders. All had lines drawn through them and the letters " D/C, " but there were no dates or initials to document when the treatments were discontinued. Additionally there was an undated entry which documented, " Cleanse (R) heel with wound cleanser. Apply Xeroform, 4x4 &amp; Kerlix. "</p> <p>Additionally during the same interview staff member #4 was asked which wound care order was the current/correct treatment order for the resident. Staff member #4 stated she did not know which wound care order was the correct order. Staff member #3 was asked if she performed resident #2 ' s wound care 7 days a week. She responded, " No, the unit nursing staff conduct the wound care on the weekends. " Staff member #4 was asked, If the weekend staff read the order on the monthly orders signed by the physician and completed the wound care per that order was it correct? ( " Cleanse right heel with normal saline, swab with betadine, apply 4x4 gauze and wrap with Kerlix " ) Staff member #4 stated, " I ' m not sure which order is the correct order. " Staff member #4 stated she would talk to the administrator to see if there were any other change orders or D/C orders for the wound care for resident #2 ' s right foot/heel and left lower leg.</p> <p>On 12/15/2011 at 1:10 p.m. an additional interview was conducted with staff member #4 who stated, " I talked to the administrator and</p>	F 314			

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F 314	<p>Continued From page 6</p> <p>she stated we needed to call the physician and get a new/clarification order from the physician to use the Xeroform on the right heel. "</p> <p>On 12/15/2011 at 1:20 p.m. an interview with the facility ' s Director of Nursing (DON) and Administrator was conducted concerning the differences in the wound care orders and the observed wound care given by staff member #3 to resident #2. The DON and Administrator reviewed resident #2 ' s medical chart but could not find any other information/orders showing a change in orders was made for resident #2 ' s wound care. The DON stated she would have to contact the facility ' s PAC to find out more information.</p> <p>On 12/15/2011 at 1:45 p.m. the Administrator provided a copy of a faxed update information notice sent by staff member #3 (wound care nurse) to the facility ' s PAC which was dated 11/16/2011. The information update notice documented resident #2 as having 2 areas on her right foot she was unable to blanch. ( " Right lateral foot has non-blanchable redness 1cm x 0.5cm. Also on bottom of right foot near heel non-blanchable area 1cm x 1cm. Removed skilled care boot and floated foot off pillow. Change treatment to right heel to Xeroform gauze per protocol. " ) The faxed information sheet was initialed by staff member #3. Under the documentation on the faxed information sheet update the following was written - " 11/16/11 Thank You (with the PAC ' s initials) "</p> <p>On 12/15/2011 at 2:45 p.m. the facility administrator and staff member #3 received a clarification/wound treatment order from the</p>	F 314			

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F 314	<p>Continued From page 7</p> <p>facility ' s PAC for the faxed information update dated 11/16/2011. This order was compared to the monthly order dated 12/01/2011. The orders were not the same.</p> <p>On 12/15/2011 at 3:25 p.m. and interview was conducted with the facility ' s Administrator and DON. They provided copies of 2 verbal orders dated 12/15/2011 for review, to discontinue resident #2 ' s left lower leg wound care and for treatment of the resident ' s right foot/heel.</p> <p>On 12/15/2011 at 4:40 p.m. an interview was conducted with resident #2 in her room. The resident was observed to be still lying on her back in her bed. Her position was unchanged from the observation during the wound care. When asked about her wound care and when the staff stopped changing the bandages on the skin tear on her left lower leg resident #2 stated, " It must be 2 or 3 weeks, they told me it was OK not to have a bandage on my left leg anymore. " Resident #2 was asked about the Bunny Boot on her left foot as observed during the wound care and the lack of a boot on her right foot. Resident #2 stated, " The nurse took the boot off my right foot about a month ago, she said I didn ' t need it anymore. " When asked if the wound care nurse had returned to her room and repositioned her since changing her bandage earlier that day, resident #2 responded, " No, I ' m here like this all the time. " Resident #2 was asked if any staff members (aids and nurses) ever came to her room to provide care and when done, changed her body position in her bed before leaving. The resident stated, " No, I can ' t move myself very good so I lay on my back most days. " During the interview resident #2 did not change</p>	F 314			



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