

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

JUN 22 2012

PRINTED: 06/11/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345383	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/30/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER CENTURY CARE OF LAURINBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 8900 HASTY ROAD LAURINBURG, NC 28352
--	--

(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
--------------------	--	---------------	---	----------------------

F 314 483.25(c) TREATMENT/SVCS TO
SS=D 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, staff interview and record review the facility failed to ensure that 1 of 3 residents (Resident #2) was free from pain during dressing change to a Stage 4 pressure ulcer.

Findings include:

Resident #2 was admitted on 12/02/11 and her diagnoses included Left Hemiplegia dominant side with contractures to multiple joints. Resident #2 developed a pressure ulcer to the right elbow on 02/22/12

The most recent Minimum Data Set (MDS) completed 04/17/12 was a significant change when the resident elected to have hospice services. The MDS also indicated the resident had a stage 4 pressure ulcer to her right elbow. The MDS indicated the resident was severely cognitively impaired, non-verbal, non-ambulatory and totally dependent on nursing staff for all activities of daily living (ADL's).

F 314

DISCLAIMER

Century Care of Laurinburg acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents.

The below response to the Statement of Deficiency and plan of correction does not denote agreement with the citation by (facility name). The facility reserves the right to submit documentation to refute the stated deficiency through informal appeals procedures and/or other administrative or legal proceedings.

ALLEGATION OF COMPLIANCE

The plan of correction is submitted as written allegation of compliance.

The below plan of correction pertains to F Tag 314.

1. a) On 5/31/12, 6/1/12, and 6/4/12, percocet 5-325 mg tablet give 1 tab via tube q 6 hours for pain was administered prior to resident #2 dressing changes. 6/5/12

b) Pain medication effective on each day given prior to resident discharge home on 6/5/12. 6/5/12

c) "Pressure ulcer clinical condition evaluation" was signed by MD, Dietary Manager, DON and family member was notified. See attachment A. 2/2/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Margaret L. Dickerson

Administrator

6/20/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other 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.

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

PRINTED: 06/11/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345383	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/30/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER CENTURY CARE OF LAURINBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 8900 HASTY ROAD LAURINBURG, NC 28352
--	--

(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
--------------------	--	---------------	---	----------------------

F 314

Continued From page 1
Resident 2's care plan dated 12/15/11 included observation "for non-verbal indicators of pain/discomfort (i.e...facial grimacing, furrowed brows, clenched eyes/jaws, tense/rigid extremities)" taking into account resident #2's expressive deficits. A review of the hospice care plan dated 4/9/12 indicated interventions for pain to include administering pain medications as ordered, monitoring the effectiveness of pharmaceutical interventions and to notify hospice care if analgesics not effective.

A review of resident #2's medical record noted a physician order dated 04/11/12 for Percocet 5-325mg tablet-Give one tablet daily as needed 15-30 minutes before dressing change.

A review of the April and May 2012 Medication Administration Records (MAR) revealed an order for Percocet 5-325mg one tablet to be given 15-30 minutes before the dressing changes. There were no initials on the MARs to indicate that Percocet had been administered related to dressing changes by any nurses for those months.

On 5/30/12 at 10:45am, an observation of wound care was done for resident #2.

The right elbow dressing had pink tingled drainage apparent through the roll of gauze dressing used to secure and pad the elbow. The outer dressing was removed exposing the dried gauze over the right elbow. The wound nurse then removed the dried gauze from right elbow. The gauze was adhered to the wound bed as it was removed. The resident moaned, flinched and grimaced as the nurse tugged at the gauze until it separated from the wound bed. There was red to

F 314

2.

a) "Pressure ulcer risk assessment" was updated on or before 6/5/12 for all residents in the facility. See Attachment B.

6/5/12

b) Audit completed by facility SDC and treatment nurse on all residents' mattresses to ensure resident at risk for further breakdown are currently placed on proper mattress. See Attachment C. Resident mattresses were changed as necessary.

6/4/12

c) "Pain evaluation" was updated on or before 6/15/12 for all residents in the facility. See Attachment D.

6/5/12

d) On or before 6/14/12, treatment team reviewed all residents, including residents with current treatment orders, to ensure appropriate pain regimen available. MD notified on 6/15/12 and order written for appropriate pain medication for residents without current order. See Attachment E.

6/14/12

3.

a) All licensed nursing staff will be re-inserviced by DON on or before June 27, 2012 on wet-to-dry dressings, proper removal, and monitoring for signs and symptoms of pain prior to dressing changes. See attachment F.

6/27/12

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

PRINTED: 06/11/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345383	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/30/2012
NAME OF PROVIDER OR SUPPLIER CENTURY CARE OF LAURINBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 8900 HASTY ROAD LAURINBURG, NC 28352		
(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	
F 314	Continued From page 2 pink drainage on the gauze was noted. The wound nurse stated the doctor changed the treatment order from Santyl to a wet to dry daily dressing on 05/17/12. The wound bed was red with pink raised areas inside the wound bed. Fresh blood was noted to the gauze used for cleaning the area with normal saline. The area measured 4.0cm x 4.5cm. The area was then covered with a normal saline dampened gauze, covered with dry gauze, a roll of gauze and secured with tape. On 5/30/12 at 6:20pm, the wound nurse stated she did not routinely pre-medicate the resident prior to dressing changes. The wound nurse stated the resident frequently reacted by moaning, grimacing and striking out with the dressing changes to the right elbow since beginning the wet to dry dressing change on 5/17/12. On 05/30/12 at 6:45pm, the DON stated it would be her expectation that the resident receive pain medication prior to the dressing changes.	F 314 4.	b) IDT to discuss new admits with treatment dressing changes during morning stand-up to ensure appropriate PRN pain medication is ordered; if not DON or designee will notify MD. This is will be on-going for all new admissions. a) Results of plan and audits will be discussed during morning administrative meeting weekly X 4 weeks with adjustments to plan made as needed with appropriate staff re-inserviced as needed, followed by: b) Results of audits and compliance with plan will be discussed and minutes recorded X 4 months during the facility's monthly QA meeting, with adjustments to plan made as needed, followed by: c) Results of audits and compliance with plan will be discussed and minutes recorded quarterly X 3 quarters during the facility's quarterly QA committee meeting, with adjustments to plan made as needed, followed by: d) Ongoing as needed.	6/27/12 and ongoing	