STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 06/20/2013

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GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVE NW LENOIR, NC 28645

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F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record reviews, physician interview, resident and staff interviews the facility failed to	F 157	**This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law.** **F 157** With regard to this alleged deficient practice, the facility has taken the following actions: 1. Resident #1's physician was notified by the nurse of increased drainage on 6/13/13 and wound care is being completed as per physician orders. Resident #2's scabbed area was noted and reported to the physician on 6/20/13 for any additional orders by the nurse. 2. All residents have the potential to be affected by the alleged deficient practice. A review of current residents skin and/or current wounds will be conducted by Director of Clinical Services/Assistant Director of Clinical Services/ Nurse Manager by 7/17/13 to note any deterioration of any resident skin and/or wound areas. Any noted deterioration to skin and/or wound areas will be documented in the resident's medical record by the nurse along with notification to	7/18/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Letta Nadeau — TITLE: Administrator — (X6) DATE: 7-15-13

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.

DHSR Mountain Area Received JUL 17 2013 by: MMH

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F 157	Continued From page 1 notify a physician of increased drainage of a vascular wound on the left lower leg and failed to notify a physician of skin breakdown on the right lower leg for 2 of 3 residents sampled with wounds. (Resident #1 and #2). The findings included: 1. Resident #1 was re-admitted to the facility on 12/17/12 with diagnoses which included cellulitis (a skin infection caused by bacteria that causes skin to be warm, red, swollen and tender) of the left (L) lower leg; a vascular wound (usually occurs on the lower legs when blood is not flowing properly through the veins) of the (L) lower leg at the (L) tibial crest (near the shin bone); swelling in lower legs; difficulty with walking; muscle weakness; kidney failure; heart failure and diabetes. The quarterly Minimum Data Set (MDS) dated 03/18/13 indicated Resident #1 had problems with short term and long term memory and was severely impaired in cognition for daily decision making. The MDS further indicated Resident #1 had range of motion impairment in both lower extremities. The MDS also indicated in Section B that Resident #1's hearing was highly impaired with absence of useful hearing and Section M for skin conditions indicated Resident #1 had one venous/arterial ulcer. A review of a physician's progress note dated 06/03/13 indicated in part Resident #1 had a history of chronic venous ulcers and cellulitis. A review of a Report of Consultation from a wound clinic dated 06/12/13 at 2:00 PM indicated:	F 157	the resident's physician for any new orders and notification to the Resident/Responsible Party. Further any changes in skin and/or wound condition will be reflected on the 24 hour report. An in-service for all licensed nurses was completed by the Director of Clinical Services (DCS) on 6/20 – 6/21/13. All Licensed Nurses were re-educated on the requirement to document changes in resident condition, including changes in skin and/or wound status in the resident's medical record. Upon recognition of a change in resident condition, the nurse will notify the resident's physician for any new orders to be carried out, along with notification to the Resident/ Responsible Party. The chain of events will be documented in the resident's medical record by the nurse and the change in condition will also be reflected on the 24 hour report. 24 hour reports will be reviewed during the daily Interdisciplinary Team Meeting Monday-Friday by the Director of Clinical Services/Assistant Director of Clinical Services/Nurse Manager. Resident's medical record will also be reviewed who have experienced a change in condition per the 24 hour report, to ensure appropriate notification of the resident's physician for new orders along with notification to the Resident/Responsible Party.	

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F 157	Continued From page 2 1. Change Unna boot (a special gauze bandage used for the treatment of venous ulcers and contains a thick creamy mixture of zinc oxide and calamine to promote healing) 2 times per week 2. Do not use foam pads to site 3. If drainage increases, increase wraps to 3 times per week 4. Apply Silvadene (a sulfa drug to prevent and treat wounds and kills a wide variety of bacteria) to (L) leg site with 4 x 4 dressings and also Unna boots 5. Please do foot care weekly; wash feet and toes 6. Recheck in 3 weeks 07/03/13 During an interview on 06/20/13 at 9:40 AM the wound care nurse explained Resident #1 was hearing impaired but communicated with sign language, read lips, spoke a few words and was able to make her needs known to staff. He explained the dressing changes were done 2 - 3 times per week. The wound nurse stated the dressing changes were very painful for Resident #1 and he changed them early this morning but he would not change the dressing again until the day it was due to be changed or when drainage saturated the dressings. He further explained Resident #1's (L) lower leg wound had increased drainage over the last 3 - 4 weeks but he did not notify the physician of the increased drainage and used a hydrofoam dressing to collect the drainage instead. He stated the wound clinic told him on 06/13/13 to stop using the hydrofoam dressing because of swelling in Resident #1's legs and the physician wanted the dressings changed more frequently because of the increased drainage. During an observation on 06/20/13 at 10:45 AM	F 157	3. The Director of Clinical Services (DCS)/Assistant Director of Clinical Services (ADCS)/Nurse Manager will conduct Quality Improvement (QI) Monitoring to ensure that with a change in condition including changes in wound and/or skin status that there is documentation in the resident's medical record and the resident's physician is notified for any new orders to be carried out by the nurse, along with notification to the Resident/ Responsible Party. Additionally QI monitoring will ensure that the change in condition is reflected on the 24 hour report. Quality Improvement Monitoring Tool will be completed 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks and then 1 x monthly for 9 months. 4. Director of Clinical Services/Assistant Director of Clinical Services will report the results of Quality Improvement Monitoring to the Quality Assurance/Performance Improvement Committee monthly x 12 months to ensure substantial compliance and/or revision.	

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F 157	Continued From page 3 Resident #1 was sitting in a wheelchair in the activity room and had a large dressing that covered her (L) lower leg from her knee down to her ankle. During an interview on 06/20/13 at 1:35 PM Resident #1 pointed to her (L) lower leg and stated "very sore" and "drained" and pointed with her right (R) index finger to the dressing on her (L) leg and to her bed. She then pointed with her (R) index finger to a small area of drainage on the dressing that was a dark brown color and approximately the size of a dime on the outer side of her (L) leg next to her ankle. During a follow up interview on 06/20/13 at 3:40 PM the wound care nurse confirmed he should have notified the wound clinic physician when the drainage increased on Resident #1's (L) leg. He further stated he should have provided wound treatments according to what the wound care physician told him to do. During an interview on 06/20/13 at 5:03 PM the Director of Nursing (DON) stated it was her expectation if there was a change in the wound the nurse should notify the wound doctor and every treatment should start and end with a physician's order. The DON stated the wound nurse should have notified the wound clinic about the increased drainage. During a phone interview on 07/03/13 at 7:29 PM the wound physician stated Resident #1 has had the vascular wound on her (L) leg for a long time and it has been slow and difficult to heal. He further stated the wound was very painful for Resident #1 so they started using compression	F 157		

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F 157	Continued From page 4 dressings with a medicated gel and then Resident #1 let them clean the wound and debride it. He explained the wound had improved with a little healing until he examined Resident #1's (L) lower leg wound on 06/12/13 when it looked worse and had deterioration of skin around the wound. He stated if the nurse at the facility had called him and told him about the increased drainage then he would have told them to change the dressing more often. He further stated that it was his expectation for them to follow his orders to promote healing and prevent further breakdown of the wound. 2. Resident #2 was admitted to the facility 05/16/13 with diagnoses including peripheral (lower extremity) vascular disease, diabetes mellitus, recent right forefoot amputation secondary to critical loss of blood flow, and gangrene to right lower extremity. A review of a Discharge Summary dictated 05/14/13 was conducted. The summary specified Resident #2 was admitted to an acute care facility with severe blood flow impairment and gangrene to her right foot. The summary documented Resident #2 had a planned discharge for 05/15/13. The Discharge Summary described the resident's hospital course involved a right forefoot amputation on 04/23/13 due to gangrene of her right forefoot. On 05/08/13, Resident #2 underwent an arterial bypass from the right femoral artery (located in the groin) to the right popliteal artery (located behind the knee) to improve blood flow to the right foot and lower extremity. An Admission Minimum Data Set dated 05/23/13	F 157		

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F 157	Continued From page 5 assessed Resident #2 as cognitively intact and able to understand and make herself understood. A care plan dated 05/23/13 specified Resident #2 was at risk for impaired skin integrity related to peripheral vascular disease and other diagnoses. The care plan goal specified skin will remain intact through the next 90 days. Interventions included weekly skin assessments were to be completed by the nurse. A review of Resident #2's medical record revealed a Weekly Nursing Progress Note dated 06/20/13 and written by Nurse #1. In the section designated review of weekly skin checks Nurse #1 had written an assessment of the resident's skin. The assessment described an open wound at the amputation site and an irritated area on the buttocks. The note specified treatments were in place for both these areas. The assessment did not include the scabbed area on the resident's right lower extremity. During an interview with Resident #2 on 06/20/13 at 2:09 PM, a scabbed area was noted midway between the right knee and ankle to the right of the shin. The area was approximately the size of a pencil eraser and closely encircled by red colored skin. Resident #2 stated she caused the open area by scratching her leg to relieve an itch about 2 days ago. An interview was conducted with Nurse #1 on 06/20/13 at 2:39 PM. Nurse #1 stated she had completed Resident #2's skin assessment. She stated she was aware of the scabbed area on the resident's right lower leg and had been watching it for a couple of days. Nurse #1 stated it was not	F 157		

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F 157	Continued From page 6 getting larger and did not appear to be infected. Nurse #1 stated the area did not cause concern. An interview was conducted with the Director of Nursing (DON) on 06/20/13 at 3:00 PM. The DON stated an incident report should have been completed when the scabbed area was first noted. She added any opening on a resident's leg should be reported and documented. The DON stated she expected all open areas were reported and documented the day they were found.	F 157		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record reviews, physician interview, resident and staff interviews the facility failed to follow physicians wound care orders to prevent deterioration of skin around a venous ulcer on the left lower leg of 1 of 3 residents sampled with wounds. (Resident #1). The findings included: Resident #1 was re-admitted to the facility on 12/17/12 with diagnoses which included cellulitis (a skin infection caused by bacteria that causes	F 309	**F 309** 1. Resident #1's wound care is being completed as per physician orders and no foam dressing is being used. Nurse was re-educated 1:1 by the Director of Clinical Services on 6/20/13 on following wound care orders as written by the Physician and to notify the Physician as needed for any needed clarification orders or further orders. 2. All residents receiving wound care have the potential to be affected by the alleged deficient practice. DCS/ADCS/Nurse Manager will complete a review of current facility residents by 7-17-13 to ensure that wound care is being performed according to the residents' physicians' orders and to notify the Physician as needed for any clarification orders or further orders. The nurse will notify the physician of	7/18/13

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F 309	Continued From page 7 skin to be warm, red, swollen and tender) of the left (L) lower leg; a vascular wound (usually occurs on the lower legs when blood is not flowing properly through the veins) of the left (L) lower leg at the (L) tibial crest (near the shin bone); swelling in lower legs; difficulty with walking; muscle weakness; kidney failure; heart failure and diabetes. The quarterly Minimum Data Set (MDS) dated 03/18/13 indicated Resident #1 had problems with short term and long term memory and was severely impaired in cognition for daily decision making. The MDS further indicated Resident #1 had range of motion impairment in both lower extremities. The MDS also indicated in Section B that Resident #1's hearing was highly impaired with absence of useful hearing and Section M for skin conditions indicated Resident #1 had one venous/arterial ulcer. A review of a Report of Consultation dated 04/04/13 from a wound clinic indicated a (L) lower leg wound was debrided today by the physician and a possible skin graft to be done at the office next week. 1. Continue Calamine Unna boot wrappings (a special gauze bandage used for the treatment of venous ulcers and contains a thick creamy mixture of zinc oxide and calamine to promote healing). 2. Continue angel paste (contains Silvadene 50 grams - a sulfa drug to prevent and treat wounds and kills a wide variety of bacteria; Lidocaine 5% - a local anesthetic to relieve itching, burning and pain and Triamcinolone 0.1% - a steroidal cream to treat swelling and inflammation). 3. Elevate feet, legs as much as possible	F 309	discrepancies related to any resident who was noted as not having wound care done per the physician's orders for any further orders. An in-service was conducted by the Director of Clinical Services on 6/20 – 6/21/13 regarding following physician orders including those related to skin and/or wound care for all current licensed nurses. New physician wound care orders will be reviewed by the Director of Clinical Services/ Assistant Director of Clinical Services/Nurse Manager five times per week Monday – Friday during the daily Interdisciplinary Team Meeting to assure all the new wound care orders have been transcribed as written to the resident's Treatment Record to further ensure proper application by the nurse. 3. The Director of Clinical Services/ Assistant Director of Clinical Services/Nurse Manager will conduct Quality Improvement Monitoring of residents' wound care to ensure it is being performed per physicians' orders. QI monitoring will be conducted 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks and then 1 x monthly for 9 months using a sample size of 2 residents and 2 nurses.	

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F 309	Continued From page 8 4. Wash feet, toes 2 times per week A review of a Report of Consultation from a wound clinic dated 04/24/13 indicated: 1. Leave (L) leg dressing intact 2. Do not change Unna boot 3. Do not apply brown stocking to (L) leg. Recheck in 1 week on 05/01/13 A review of a Report of Consultation from a wound clinic dated 05/01/13 indicated: 1. Continue plan - do not redress wound - leave intact 2. Next visit 05/08/13 A review of a Report of Consultation from a wound clinic dated 05/08/13 indicated: 1. Discontinue previous treatments to (L) tibial crest 2. Leave dressing intact for 1 week 3. Cleanse wound with wound cleanser. Apply Mepetil (a non-stick silicone dressing) and secure with steristrips. Cover with dry 4 x 4 dressings and wrap with Unna boot every week. 4. Follow up in wound clinic in 1 month A Review of a facility document titled "Non-Pressure Skin Condition Record" dated 06/03/13 indicated (L) lower leg venous ulcer was 9 centimeters (cm) long x 6 cm wide x 0.1 cm deep. The notes further indicated there was small to medium drainage, there was no odor, wound edges were firm and the skin around the wound was intact. A review of a Report of Consultation from a wound clinic dated 06/12/13 at 2:00 PM indicated: 1. Change Unna boot 2 times per week	F 309	4. The Director of Clinical Services/Assistant Director of Clinical Services will report the results of Quality Improvement Monitoring to the Quality Assurance/Performance Improvement Committee members monthly x 12 months for continued substantial compliance and/or revision.	

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F 309	Continued From page 9 2. Do not use foam pads to site 3. If drainage increases, increase wraps to 3 times per week 4. Apply Silvadene (a sulfa drug to prevent and treat wounds and kills a wide variety of bacteria) to (L) leg site with 4 x 4 dressings and also Unna boots 5. Please do foot care weekly; wash feet and toes 6. Recheck in 3 weeks 07/03/13 During an interview on 06/20/13 at 9:40 AM the wound care nurse explained Resident #1 was hearing impaired but communicated with sign language, read lips, spoke a few words and was able to make her needs known to staff. He further explained she went to the wound clinic every 4-6 weeks and her most recent visit was last week on 06/12/13. He stated the wound clinic made wound care recommendations and sent treatment orders back to the facility and the resident's primary physician reviewed the orders and either accepted or rejected them but he had never seen the primary physician reject a wound care recommendation. He explained the dressing changes were done 2 times per week but could be increased to 3 times per week for drainage as needed. The wound nurse stated the dressing changes were very painful for Resident #1 and he had changed Resident #1's dressing early this morning but he would not change the dressing again until the day it was due to be changed or when drainage saturated the dressings. He described the current treatment plan for Resident #1's (L) lower leg wound was to apply Silvadene cream to the wound and place a Unna boot with a pleated wrapping to cover her (L) lower leg. He further explained he put a hydrofoam dressing on Resident #1's wound in	F 309		

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F 309	Continued From page 10	F 309		

addition to the dressings the wound physician had ordered because the wound had excess drainage and he thought the foam would collect the drainage. He stated he called the wound clinic on 06/13/13 for clarification of physician's orders and they told him to stop using the hydrofoam dressing because of swelling in Resident #1's legs and the physician wanted the dressings changed more frequently because of the increased drainage.

During an observation on 06/20/13 at 10:45 AM Resident #1 was sitting in a wheelchair in the activity room and had a large dressing that covered her (L) lower leg from her knee down to her ankle.

During an interview on 06/20/13 at 1:35 PM Resident #1 pointed to her (L) lower leg and stated "very sore" and "drained" and pointed with her right (R) index finger to the dressing on her (L) leg and to her bed. She then pointed with her (R) index finger to a small area of drainage on the dressing that was a dark brown color and approximately the size of a dime on the outer side of her (L) leg next to her ankle.

During a follow up interview on 06/20/13 at 3:40 PM the wound care nurse explained he used the hydrofoam wound dressings when he changed Resident #1's dressings 2-3 times per week over the last 3 - 4 weeks. He confirmed there was no physician's order for the hydrofoam dressings he used on Resident #1's (L) leg wound and there were no standing orders or protocols for hydrofoam dressings but it was his nursing judgement to use them to collect excess drainage. He further stated he should have

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F 309	Continued From page 11 provided wound treatments according to what the wound care physician told him to do. During an interview on 06/20/13 at 5:03 PM the Director of Nursing (DON) stated it was her expectation for the wound nurse to follow the physician's orders. She further stated if there was a change in the wound the nurse should notify the wound doctor and every treatment should start and end with a physician's order. The DON stated the wound nurse should have notified the wound clinic about the increased drainage and should not have put the foam dressing on the wound without orders to do so. During a phone interview on 07/03/13 at 7:29 PM the wound physician stated Resident #1 has had the vascular wound on her (L) leg for a long time and it has been slow and difficult to heal. He further stated the wound was very painful for Resident #1 so they started using compression dressings with a medicated gel and then Resident #1 let them clean the wound and debride it. He explained the wound had improved with a little healing until he examined Resident #1's (L) lower leg wound on 06/12/13 when it looked worse because of deterioration of skin around the wound. He stated he saw the foam dressing that had been applied to the wound and when it was removed there was skin breakdown around the edges of the wound and he estimated the foam dressing had caused a 10 percent increase in the size of the wound. He further explained if staff had cut the foam dressing to the size of the wound and trimmed the dressing with a beveled or sloped edge it would have helped drain the wound but it was too thick and caused pressure that caused deterioration of the skin around the	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 06/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 12 wound. He stated if the nurse at the facility had called him and told him about the increased drainage then he would have told them to change the dressing more often. He further stated that it was his expectation for them to follow his orders to promote healing and prevent further breakdown of the wound.	F 309		