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	345478	A. BUILDING _____ B. WING _____	C 11/14/2013

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HARNETT WOODS NURSING AND REHABILITATION CENTER	604 LUCAS RD DUNN, NC 28334

(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 309 SS=D	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 observation, record review, staff and private sitter interviews, a sitter failed to feed a resident in a manner in which the resident was not positioned at risk for choking for 1 of 2 residents reviewed for feeding (Resident #1). The findings included: A review of the facility policy titled "sitters" dated 2/2009 in part read "the facility is responsible for the care provided to their residents." Resident #1 was admitted into the facility on 2/4/10. Diagnoses included in part Dementia, Alzheimer's and cataract. The quarterly minimum data assessment (MDS) completed on 10/7/13 revealed Resident #1 had short and long term problems. Decision making was listed as moderately impaired. The MDS revealed Resident #1 required extensive assistance of one person physical assist with eating. Limited range of motion to one side of the upper extremity (shoulder, elbow, wrist and hand) was indicated as impaired. A review of the care plan titled "resident care guide" dated 10/8/13 in part read "assist with	F 309	RESPONSE PREFACE Harnett Woods Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and propose this plan of correction to the extend that the summary of findings its factually correct and in order to maintain compliance with applicable rules and provisions of quality care of the residents. The plan of correction is submitted as a written allegation of compliance. Harnett Woods Nursing and Rehabilitation response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further Harnett Woods reserves the right to submit any documenation to refute any of the stated deficiencies on this Statement of Deficiencies through the informal dispute resolution formal appeal procedure and/or any other administrative legal proceeding.	12/5/13

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

Electronically Signed | 12/03/2013

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.

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F 309	Continued From page 1 eating - feed as needed." During an observation on 11/14/13 at 8:50 am, Resident #1 was observed in the bed positioned at 35 degrees while being fed by sitter B. The resident was observed with continued coughing, while being fed bacon, toast, milk and coffee through a straw by sitter B. On 11/14/13 at 8:55 am, Resident #1 remained in bed positioned at 35 degrees with continued coughing while being fed by sitter B. Nurse #1 when questioned during an observation from outside the opened door of Resident #1's room regarding the positioning of Resident #1 while eating stated the resident was positioned at 30-45 degrees. She immediately went into the room and informed sitter B that the resident needed to be positioned at 75 degrees or higher while eating. Nurse #1 positioned the resident to 75 degrees by raising the head of the bed. In an interview on 11/14/13 at 9:00 am, private sitter B indicated that she was hired one month ago by the guardian of Resident #1 as a "private sitter." She stated that part of her duties included "feeding Resident #1 because he played with his food and would not eat at times." The sitter added that she obtained the meal tray when the nursing assistants brought the tray in the room to her every morning. She concluded that she had no formal training related to feeding residents. In an interview on 11/14/13 at 9:45 am, the director of nursing (DON) indicated that she had no control over the private sitter, and that she had not assessed or observed if the sitter was capable of safely feeding Resident #1, due to the sitter was not hired by the facility. The DON concluded that her expectation was if the facility	F 309	On November 15, 2013 and November 16, 2013 the facility provided resident #1□s private sitters with training regarding proper feeding techniques including correct positioning of the resident during feeding by the Director of Nursing and Administrative nurses. Any new sitters for Resident #1 will be trained prior to sitting with him on the proper feeding techniques to include correct positioning. On November 15, 2013 the facility completed a 100% audit of other residents with private sitters to identify other residents at risk for the same deficient practice. An in-service regarding proper feeding techniques including proper positioning of residents during feeding was begun with these sitters by the Staff Facilitator on November 15, 2013 and completed on November 18, 2013. The Staff Facilitator (RN) will in-service any new private sitters on the proper feeding process including proper positioning of resident prior to their beginning to work with a resident. An audit tool was begun by the Quality Assurance Nurse and the Director of Nursing on November 18, 2013 to review proper feeding techniques by private sitters to include Resident #1. The Monitoring Audit tool will be completed weekly to ensure proper techniques are being followed. The Director of Nursing and/or the Assistant Director of Nursing will review	

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F 309	Continued From page 2 staff observed the sitter feeding Resident #1 incorrectly, to educate the sitter, to elevate the head of the bed at a level to prevent the resident from choking.	F 309	the results of the audit tool weekly X 4 weeks and monthly X 2 months. The DON/ADON will follow up immediately on any concerns identified. The results of the Audit Tool will be shared monthly with the Executive QI Committee X 2 months. Additional action will occur if deemed necessary and to determine the need and/or frequency for continued monitoring.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO 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, record review, staff, physician, and surgeon interviews, the facility failed to conduct routine skin assessments and also failed to relieve pressure while a resident was sitting in the wheelchair by not repositioning the resident, who was at risk for pressure ulcer for 1 of 1 resident reviewed for pressure ulcers (Resident #1). The findings included: A review of the facility pressure ulcer prevention policy dated 11/2012 as a procedure for pressure ulcer prevention read in part "1) turn and	F 314	The facility completed a full body assessment on Resident #1 on November 18, 2013 with no additional concerns identified. An in-service was completed on November 18, 2013 by the Nurse Consultant with the Treatment Nurse on All Ulcer and Non-Ulcer skin conditions being assessed weekly to include Resident # 1. An in-service with 100 % of the Nursing Staff was begun by the Staff Facilitator on November 18, 2013 on Reporting Skin Changes to include	12/5/13

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F 314	Continued From page 3 reposition the patient and place on a turning schedule 2) inspect skin and notify appropriate personnel of abnormal changes. Note: Remember that skin inspections are done in different ways. They are done many times throughout the day during daily care by certified nursing assistants and licensed personnel. Abnormalities, if any, are then noted. Skin inspections are also done by treatment nurses during treatments." Resident #1 was admitted into the facility on 2/4/10. Diagnoses included in part Dementia, Alzheimer's, chronic kidney disease, postsurgical aortocoronary bypass, heart value replacement, anemia, depression, and lack of coordination. The quarterly minimum data set (MDS) completed on 6/9/13 indicated Resident #1 had problems with short and long term memory. Decision making was indicated as moderately impaired. The resident was listed at risk for pressure ulcer development; no pressure ulcers were indicated. The annual MDS completed on 8/9/13 revealed Resident #1 had short and long term problems. Decision making was listed as moderately impaired with no behaviors or rejection of care indicated. The MDS revealed Resident #1 required extensive assistance of one person physical assist with bed mobility. Total dependence of two plus persons physical assist was required with transfer. Total dependence of one person physical assist was required with locomotion on/off the unit, personal hygiene and bathing. The upper extremity was indicated as impaired on one side (shoulder, elbow wrist, hand). Urinary and bowel pattern read "always incontinent." Skin was listed at risk for developing pressure ulcer with one stage 3 pressure ulcer that measured 4.7 cm	F 314	Resident # 1. An in-service with 100 % of the Nursing Staff was begun on November 18, 2013 by the Staff Facilitator to include Resident # 1 on Pressure Ulcer Prevention which included repositioning and pressure relieving devices while in a wheelchair. The facility completed on November 20, 2013 a 100 % full body audit on all residents with no new concerns identified. An in-service was completed on November 18, 2013 by the Nurse Consultant with the Treatment Nurse on All Ulcer and Non-Ulcer skin conditions being assessed weekly. An in-service with 100 % of the Nursing Staff was begun on November 18, 2013 by the Staff Facilitator on Reporting Skin Changes. An in-service was begun on November 18, 2013 by Staff Facilitator on Pressure Ulcer Prevention which included repositioning and pressure relieving devices while in a wheelchair. The Staff Facilitator (RN) will in-service all new nursing staff on reporting changes in skin to the proper person during orientation. An audit tool was begun by the Quality Assurance Nurse and the Director of Nursing on November 21, 2013 to review that all weekly wound/non wound assessments have been completed to include Resident #1. The Monitoring Audit tool will be completed weekly to ensure skin assessments are being completed with appropriate follow up action taken	

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F 314	Continued From page 4 (centimeters) length x 3.6 cm width x 0.4 depth with slough and a feet infection indicated as "other skin problems." The care area assessment for the MDS completed on 8/19/13 listed as a problematic care area "resident with actual skin beak down stage 3 to right outer foot." As a goal, the intervention read "pressure ulcer will not worsen through next review, staff to monitor skin, report changes, treatment per protocol, positioning as tolerated, assist with meals/encourage and provide incontinent care." The care plan revised on 6/21/13 revealed that Resident #1 required the use of a mechanical lift. Revision to the care plan on 8/8/13 indicated at risk for skin breakdown related to incontinence. Interventions read "staff to report to nurse any red or open area, inspect skin and notify nurse of abnormal changes per facility protocol." The care plan revised on 8/8/13 in part read "staff to report to nurse any red or open areas, encourage and assist resident to change positions i.e., out of bed daily, boosting in wheelchair; apply barrier cream as needed, assess incontinence and treat and/or manage accordingly. Educate significant other regarding the causes of pressure ulcers, rationale for intervention, treatment and prevention strategies, inspect skin and notify nurse of abnormal changes per facility protocol." The care plan indicated that Resident #1 was at risk for bruises and skin tears due to plavix (a blood thinner) and combative/resistive behaviors at times during care. As an intervention, the care plan in part read "weekly assessment of skin integrity impairment (skin tears) with notification of physician of changes as appropriate."	F 314	upon identification of any concern by the Director of Nursing or the Quality Assurance Nurse . The Director of Nursing and/or the Assistant Director of Nursing will review the results of the audit tool weekly X 4 weeks and monthly X 2 months. The DON/ADON will follow up immediately on any concerns identified. The results of the Audit tool will be shared monthly with the Executive QI Committee X 2 months. Additional action will occur if deemed necessary and to determine the need for and/or frequency of continued monitoring.	

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A review of the preventive interventions dated 7/15/13 read "turn and reposition, incontinent care, high density foam replacement."

A review of the quarterly "predicting risk of pressure ulcer development" tool completed by the treatment nurse on 7/15/13 indicated that Resident #1 was assessed "high risk." Additional assessment indicated "physical condition fair", "mobility very limited", "confused mental status" and "chair bound."

A review of the weight summary revealed the following weights: 7/15/13 (174), 8/14/13 (176), and 9/10/13 (178).

A review of the nurse's progress notes completed by Nurse #1 on 9/9/13 read in part "called to room by nursing assistant (NA) observed an abrasion to left buttocks, area also witnessed by the treatment nurse and duoderm treatment rendered. No sign/symptoms pain/discomfort."

A review of the flow sheet titled "non-ulcer skin condition" form completed by the treatment nurse on 9/11/13 read: "abrasion to the left buttock with, small amount of bleeding noted." Treatment implemented read "cleanse with normal saline cover with tegaderm, check every day, change 5-7 days and as needed."

A review of the treatment record for September 2013 read "cleanse left buttock with normal saline, cover with duoderm every day and as needed." The flow sheet was initialed to reflect that treatment was provided 9/9/13 through 9/23/13. The treatment record was not initialed to reflect that care was provided on 9/21/13.

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A review of the registered dietitian progress note dated 9/23/13 in part read "no significant weight changes x 30/90/180 days, consumes 50-100% of regular, continues with megace to help with appetite, meeting nutritional needs with by mouth diet at this time."

A review of the progress notes from 8/2/13 through 10/2/13 revealed no specific rejection of care by Resident #1. The nurse's progress note dated 8/16/13 read "resident was resistive to care at times, however, no adverse behaviors reported." Documentation reflected the resident exhibited periods of confusion at times, resident was turned and repositioned frequently, and the left buttock duoderm was indicated as intact.

A review of the nurse's progress notes completed by the treatment nurse on 9/23/13 read in part "in to assess buttocks areas noted to left buttock stage III measures 3 cm (centimeters) x 3 cm, unstageable right buttock measures 4.2 cm x 4.5 cm, and the coccyx stage III measures 1 cm x 2 cm. Periwound on all three wounds is hard to touch. Physician called and made aware, gave orders to refer to wound clinic, appointment made for 9/30/13."

A review of the "wound/ulcer flow sheet" completed on 9/25/13 by the treatment nurse read as follow:

1. "Occurred in-house: left buttock unstageable pressure ulcer 5.5 cm (length) x 4.5 cm (width), with no tunneling, undermining, odor, exudate, infection or necrosis, 50% braoen eschar, 50% granulating tissue, peri-wound appearance dry/intact and no pain."
2. "Occurred in-house: right buttock

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unstageable pressure ulcer 3 cm (length) x 2.5 cm (width) with no tunneling, undermining, odor, exudate, infection or necrosis, 50 % brown eschar, 50% granulating tissue, peri-wound appearance dry/intact and no pain."
3. "Occurred in-house: coccyx stage III pressure ulcer 2 cm (length) x 2 cm (width) with no tunneling, undermining, odor, exudate, infection or necrosis, 90% granulating. 10% slough, peri-wound appearance dry/intact and no pain."

Treatment per the "wound ulcer flow sheet" dated 9/25/13 for the above three pressure ulcers (left buttock, right buttock, and coccyx) read "cleanse with normal saline, cover with hydrocolloid dressing, change every seven days and as needed." Preventive interventions included: turn/reposition, protection and containment (brief), high density foam replacement.

A review of the treatment record from 9/23/13 - 10/1/13 revealed a treatment change to the left buttock, right buttock, and coccyx that read "cleanse with normal saline, apply hydrocolloid dressing, change every seven days and as needed." The record was initialed that treatment was provided.

A review of the hospital record revealed on 10/2/13 Resident #1 had a "very large sacral decubitus that was debrided."

A review of the skin/wound treatment note completed by the treatment nurse on 10/3/13 revealed Resident #1 underwent a surgical debridement on 10/2/13 to the coccyx, left buttock and right buttock, that resulted in all three wounds became one wound after the surgical debridement.

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A review of the "wound ulcer/ulcer flow sheet" post surgical debridement completed on 10/3/13 by the treatment nurse read as follow:

1. "Occurred in-house: sacrum unstageable pressure ulcer 10.5 cm (length) x 8 cm (width) x 4.5 cm (depth) with undermining 3.5 cm between 1:00 and 2:00, no odor, exudate, infection or necrosis, granulating tissue to wound bed and peri-wound dry/intact, pain during dressing change, as needed pain medication." Treatment read "cleanse with normal saline, pack with alignate packin cover with foam dressing, and an abdominal pad every day and as needed for soilage." Preventive interventions included: protection and containment (brief), high density foam replacement.

During an observation on 11/13/13 at 1:45 pm, Resident #1 was observed positioned on his back. A specialty mattress was observed on the bed and a support pillow was observed between the resident knees.

During a wound observation on 11/13/13 at 1:55 pm accompanied by the treatment nurse, Resident #1 was observed with a large sacral wound that had been surgically debrided. The inner wound appearance was pinkish-redden with depth. No active bleeding, drainage, or odor was observed. During the observation the treatment nurse stated that the wound started out as an "abrasion to the left buttock."

In an interview on 11/13/13 at 5:01 pm, the director of nursing (DON) accompanied by the treatment nurse indicated that the nursing assistants were responsible for reporting skin

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abnormalities observed during bed baths or showers immediately to the charge nurse. The DON added that the nursing assistants are instructed to turn and reposition bed/chair bound residents throughout the day. The DON stated that baths are documented in the electronic system and that's how she is assured that baths are being provided and skin is assessed. She added that if the nursing assistants did not notify the charge nurse of any skin concerns, then she was sure that there were no identified skin concerns. The DON concluded that the nurses and the treatment nurse were expected to observed changes in residents' skin at any time.

In a follow-up interview on 11/14/13 at 10:00 am, NA #1 when questioned had she provided any bed baths or showers to Resident #1 indicated that the resident use to go to the shower room prior to the "sore on his buttocks." She concluded that she had never given him a shower, nor had she observed any concerns with his skin condition during routine care, which included bed baths leading up to the "sore on his buttocks."

In an interview on 11/14/13 at 10:03 am, Nurse #1 when questioned regarding skin assessments indicate that the NAs were responsible for reporting any changes in residents' skin condition to the charge nurse that was observed during baths, showers, or routine care. She stated that she was not notified of any conditional changes in Resident #1's overall skin condition by the NAs. She indicated that throughout the day during her med pass, when walking in/out of resident rooms, if she observed the NAs giving a resident a bed bath, shower, or dressing the resident, she would observe for any skin abnormalities at that time. Nurse #1 concluded during the last 3 months she

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had not completed a routine skin assessment on Resident #1.

In an interview on 11/14/13 at 11:50 am, physician #1 acknowledged that she was Resident #1 primary physician and that she visited the facility monthly. She indicated that she recalled the facility informing her that Resident #1 was observed with an abrasion on his buttocks and that she ordered the resident to been seen by an outside surgeon, since he was already being seen for his feet as a precautionary measure. Physician #1 concluded that considering Resident #1's extensive cardiovascular history, bilateral lower leg/feet edema, aortic valve disease and fragile status that she believed the pressure ulcers to the sacral/buttocks area were unavoidable.

In an interview on 11/14/13 at 2:02 pm, the treatment nurse, accompanied by the DON when questioned regarding the appearance/shape of the left buttock abrasion when she witnessed it on 9/9/13 stated it was "just an abrasion to the left buttock and a description was not necessary per the facility protocol for abrasion." When further questioned regarding the worsening of the abrasion appearance or surrounding skin tissue, the treatment nurse referred back to the facility's abrasion protocol. She stated she provided treatment as ordered by the physician to the left buttocks and could not provide a physical description of how the left buttock or the surrounding skin integrity appeared on 9/12/13 through 9/22/13. The treatment nurse acknowledged that she performed treatment to the left buttocks "abrasion" on 9/9, 9/10, 9/11, 9/12, 9/13, 9/18, 9/19, 9/20 and 9/23 per the treatment record. She stated that she did not

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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
F 314	Continued From page 11	F 314		

observe any changes in the abrasion or other skin concerns until 9/23/13. The treatment nurse acknowledged on 9/23/13 she assessed the following wounds as follow: "1) stage III left buttock measured 3 cm x 3 cm 2) unstageable right buttock measured 4.2 cm x 4.5 cm 3) stage III to coccyx measured 1 cm x 2 cm." She concluded thereafter, she notified the physician and received orders for the resident to be evaluated at the wound clinic.

In a follow-up interview on 11/14/13 at 2:32 pm, Nurse #1 when questioned regarding the left buttocks "abrasion" identified by her on 9/9/13 she indicated that she observed a "small, tiny area of the skin that was broken open. I assessed the whole entire buttocks area and did not see any other skin concerns at that time. I documented that it was an abrasion and I believed the resident was in the bed during my observation."

In an interview on 11/14/13 at 5:27 pm, NA #3 revealed that she was a floater throughout the facility but worked 3 - 4 days a week with Resident #1 prior to his wound surgery. She added that prior to the surgery and "sores on his bottom" he required the use of the mechanical lift for transferring, was unable to position himself when in the wheelchair, and that most of his time throughout the day was spent in the wheelchair. NA #3 acknowledged that she did not reposition Resident #1 when he was up in the wheelchair because she could not manage his weight. NA #3 concluded that Resident #1 was usually put to bed around 7:30 pm after dinner, and that she did not observe any skin abnormalities during routine care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345478	A. BUILDING _____ B. WING _____	C 11/14/2013

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In an interview on 11/14/13 at 5:35 pm, NA #4 stated that she had worked with Resident #1 one - two times a week and that he was usually out of bed up in the wheelchair during the evening hours. NA #4 added that the resident was limited in repositioning himself alone. She explained that the NAs are suppose to reposition the residents every two hours and as needed. She stated that she observed an "abrasion" on his left buttocks, but could not recall the exact date and she reported it to Nurse #1.

Nurse #2 who worked on 9/21/13 was not available to be interviewed during the survey, as to why the treatment record was not initialed to reflect that treatment was provided to Resident #1's left buttock.

In a telephone call interview on 11/18/13 at 4:50 pm, the surgeon revealed that when he first saw or evaluated Resident #1's pressure ulcer to the sacral area he assessed phase three pressure ulcers to the sacral, meaning that the tissue was "necrotic/dead." He elaborated that Resident #1 was immediately, taken to the operating room and surgery was performed which revealed "necrotic tissue was confirmed all the way to the bone and was surgically removed as such." The surgeon indicated taking into consideration Resident #1's overall health condition that if the resident was turn and repositioned every two hours as needed, that a phase three pressure ulcer probably would not have occurred. He stated that it was not uncommon for a phase II ulcer to develop within 30 min - 1 hour if the pressure is not relieved to the area, even with turning/repositioning every two hours. He concluded that his initial assessment of Resident #1's buttock/sacral/coccyx area revealed

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F 314	Continued From page 13 prolonged pressure was the contributing factor of the pressure ulcers, which required a surgical intervention.	F 314		