STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING ______ B. WING ______	C 12/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

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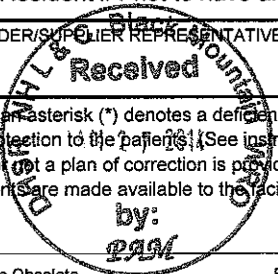
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that 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 observations, record review and staff interviews the facility failed to provide treatment to promote healing of pressure ulcers on the right buttock and left calf for 1 of 3 residents reviewed for pressure ulcers. (Resident #1) The findings included: Resident #1 was admitted to the facility 12/03/08 with diagnoses which included diabetes. Resident #1's most recent Quarterly Minimum Data Set (MDS) dated 09/30/13 assessed her as having severe cognitive impairment. Further review of Resident #1's MDS revealed she needed extensive assistance with bed mobility and transfer. The MDS assessed Resident #1 as being at risk for pressure ulcers but not having a pressure ulcer. Review of Resident #1's care plan updated 10/11/13 revealed she was at risk for pressure ulcers related to decreased mobility and intermittent incontinence of bowel and bladder. The goal was for Resident #1 not to have any	F 314	**" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."** 1. Resident #1's wound(s) were assessed by the Unit Manager (UM)and orders obtained, and implemented, for treatment to promote healing on December 30, 2013. The Registered Nurse (RN) Unit Manager completed a head to toe skin assessment for Resident #1 on December 31, 2013. No new areas were noted. The Nurse Practitioner assessed Resident #1 on December 31, 2013 with no additional treatments ordered. Resident #1 is followed by an outside wound care physician, next appointment is scheduled for January 29, 2014. Resident #1's care plan has been reviewed and updated to reflect the resident's current skin condition. An updated Braden Scale assessment for predicting pressure sore risk was completed for Resident # 1 on January 15, 2014 The resident's attending physician assessed the resident on January 15, 2014 Head to toe skin observations / assessments are conducted weekly by a licensed nurse for Resident #1. 2. Residents with pressure ulcers and those at risk to develop pressure ulcers/sores have the potential to be affected by the same alleged deficient practice. A skin sweep for residents	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 1-24-14



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 314	Continued From page 1 pressure sores through the review date of 01/03/13. Interventions were in place to prevent pressure ulcers which included an air mattress on bed, to keep resident off of affected area, and limit head of bed elevation to 30 degrees while in bed. Physician's orders dated 12/06/13 revealed an order to begin skin sweep weekly each Friday 3-11 shift, measure wounds as applicable. Physician's orders dated 12/11/13 revealed an order to clean right buttock wound with normal saline, pat dry and apply a foam dressing. Change dressing daily and as needed, assess pain prior to, during and after dressing change. This was a telephone order signed by the Nurse Practitioner. Nurse's notes dated 12/16/13 revealed notes from Interdisciplinary Team meeting there was no mention of the wound on the resident's right buttock. Nurse's notes dated 12/26/13 at 11:30 AM revealed "open area noted to posterior calf." The note further revealed Resident #1's family was notified and an attempt was made to call the wound doctor and a message was left. There was no further mention to provide treatment to this wound. On 12/30/13 at 2:17 PM an observation was made of wound care to Resident #1's wounds. Wound care was provided by Nurse #1 and Nurse #2. Nurse #2 then removed the dressing from Resident #1's right buttock wound. The dressing was saturated with tan drainage. The wound was approximately the size of a 50 cent	F 314	currently residing in the facility was conducted by the Unit Manager and/or other designated licensed nurse beginning December 31, 2013 and completed on January 3, 2014. Residents currently residing in the facility with pressure ulcers have been identified. Physician orders and Treatment Administration Records (TARS) were reviewed for those residents with current pressure ulcers to ensure current treatment orders were present and implemented. On January 15, 2014 the Director of Nursing (DON) and the Unit Managers updated the Braden scale for residents currently residing in the facility to determine potential changes in residents' risk to develop pressure ulcers. Residents determined to be at very high, high or moderate risk to develop pressure ulcers and those with current pressure ulcers were reviewed by the RD on or before January 18, 2014 for potential nutritional needs. The therapy department has screened residents determined at risk as described above to identify additional positioning needs. Care plans were reviewed/updated as needed with changes to interventions. Any discrepancies were immediately addressed. 3. Measures to be implemented by the facility to ensure the alleged deficient practice does not reoccur include: Changes in a resident's skin condition will be identified; a) via a weekly head to toe skin sweep/observation/assessment conducted by a licensed nurse. The results of the weekly skin sweep will be documented on the "Weekly Skin Integrity Review" form. b) Certified Nursing Assistants (C.N.A.) will complete a skin check during the normal daily course of care of their assigned residents. Changes	

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F 314	Continued From page 2 piece; the area was very red and raw with the top layer of skin off. Nurse #2 cleaned the wound and applied the bordered foam dressing. During wound care Nurse #1 or Nurse #2 did not assess or provide treatment to the wound on Resident #1's calf area. On 12/30/13 at 4:16 PM an interview was conducted with the Unit Manager (UM). The UM stated she was unaware of the wounds on Resident #1's buttocks area but she was aware of the wound on her calf area. She was unable to explain why there was no treatment ordered for the resident's calf wound. On 12/30/13 at 4:30 PM an observation was made with the UM of Resident #1's calf area. The wound was approximately the size of a quarter and beefy red. There was no dressing to this wound which was covered by the multi-podus boots the resident was wearing. On 12/30/13 at 4:40 PM an interview with the UM was conducted. The UM explained the area on Resident #1's calf was where the multi-podus boot had stuck to the skin and when it was removed it caused the wound. She stated she had measured the wound on Resident #1's left buttock but did not notice the wound on her right buttock. She stated she did not see the wound because of the way the resident was laying. On 12/31/13 at 8:40 AM an interview was conducted with the Wound Doctor (WD). The WD stated he sees Resident #1 at an outside wound clinic. He stated the last time he saw Resident #1 on 12/19/13 he assessed the wounds on her sacral area. He stated the resident's immobility, incontinence and her size are factors in her skin	F 314	or concerns about a resident's skin noted by the C.N.A. will be reported to the charge nurse immediately. The licensed nurse will assess the resident. New pressure ulcers or other new skin issues identified during a skin sweep or through reports from C.N.A. staff, residents, families or other staff members will be documented on the "S.B.A.R" (Situation, Background, Assessment/ Appearance, Request). The resident's responsible party will be notified of the condition change identified. The physician , nurse practitioner or on-call physician/extender will be notified of abnormal findings and an order obtained for treatment. The order(s) received will be transcribed to the Treatment Administration Record (TAR) and implemented when received and processed. The licensed nurse will also notify the UM, Supervisor or DON. The licensed nurse will note the change of condition on the 24 hour Report Communication Form, noting that an SBAR has been completed. The DON/UM will review the 24 hour Report and completed SBAR forms to determine change of condition during Morning Meeting, Monday-Friday. The UM or other designated licensed nurse will complete an assessment of the new pressure ulcer and follow-up to ensure physician orders have been obtained and implemented for changes of condition related to new pressure ulcers/ other skin related issues. In addition, the DON/UM/Supervisor/ or other designated licensed nurse will monitor completed weekly skin sweep results at least five times/week for 90 days, then at least weekly on-going, reconciling that orders are present for pressure ulcers and other skin related issues. Residents with pressure ulcers will be reviewed during the weekly Wound meeting by	

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F 314	Continued From page 3 breakdown. The WD stated the wounds on the residents buttocks were superficial but where still considered pressure wounds. On 12/31/13 at 9:53 PM an interview was conducted with the Nurse Practitioner (NP). The NP stated the order on 12/11/13 was because a nurse had called her to notify her of the wound on the resident's right buttock and she gave the order for the dressing to the right buttock. On 12/31/13 at 9:35 AM an interview was conducted with the UM. The UM explained the process for wound assessment and treatment. The UM stated during their morning meeting they go over the 24 hour report and telephone orders are reviewed. She stated between those two things she generated her list for skin issues. She stated she would then assess and measure the wounds and make sure there are treatments in place. The UM explained if they require a wound care consult she would obtain those orders. The UM further explained there was a meeting every week to discuss wounds and care plans were looked at to make sure they are updated. The UM stated she was not sure what happened with Resident #1's order for the treatment for her right buttock wound. She stated she should have measured the wound and reviewed the treatment and added it to the care plan. She stated she was aware of the wound on the resident's left calf. The UM explained there should have been an order for treatment for the calf wound. She stated because it was the end of the month and she was working on other things it fell through the cracks. On 12/31/13 at 11:42 AM an interview was conducted with the Director of Nursing (DON). The DON stated there should have been a	F 314	members of the Interdisciplinary Team (IDT). The IDT meeting will include a review, update or the development of a care plan specific to the progress of pressure ulcers and changes or additions to specific interventions to promote healing of the ulcer(s). Licensed Nursing staff will be educated by the DON/UM/Supervisor on the above process for identifying, obtaining treatment orders, communicating and documenting new pressure ulcers beginning January 17, 2014 through January 28, 2014. Nurses who have not completed the training on or before January 28, 2014 will not be allowed to work their next shift until training is completed. C.N.A. Staff will be re-educated regarding conducting skin checks during regular care activities and reporting to the charge nurse immediately if any changes to the resident's skin are noted. Training for the ancillary staff began on January 17, 2014 and will continue through January 28, 2014. After January 28, 2014 ancillary staff will not be allowed to work the next scheduled shift until training has been completed. Responsibilities of the certified nursing assistant and the licensed nurse regarding pressure ulcers will be incorporated in the facility's orientation for newly hired nursing staff. 1.The DON will report the results of the Quality Improvement monitoring to the Quality Assurance/ Performance Improvement Committee monthly x 12 months for continued substantial compliance and/or revision. 2.Allegation of Compliance Date: January 28, 2014.	

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F 314	Continued From page 4 treatment ordered for the calf wound. She stated this wound should have been documented and treated. The DON explained normally the wounds would have been brought up in the weekly meeting when they went over new orders and the 24 hour reports. Then they should have been followed up on. The DON stated the care plan should have been updated to reflect the buttock wounds with measurements.	F 314		