STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345505	A. BUILDING _____ B. WING _____	C 03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA REHAB CENTER OF CUMBERLAND	**4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306**

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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 observations, record review, and staff and resident interviews, the facility failed to provide ordered wound treatments for 1 of 3 sampled residents (Resident #1) reviewed for pressure ulcers. Findings included: Resident #1 was admitted on 1/16/15 with diagnoses that included cellulitis of lower extremities, muscle weakness, and cardiovascular disease. The Minimum Data Set (MDS) completed on 2/13/15 assessed the resident as cognitively intact, having limited mobility of both lower extremities and requiring extensive assistance for transfer, bed mobility, and personal hygiene. The MDS assessed the resident as having two stage two pressure ulcers present on admission, at risk for further skin breakdown, and requiring a pressure relieving mattress. Review of the resident ' s initial skin assessment dated 1/16/15 revealed the presence of a sacral split/fissure, a stage two pressure ulcer on the left and right gluteal fold, cellulitis below the knee on both legs, and excoriation of the abdomen under	F 314	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F. 314 How the corrective action will be accomplished for the resident(s) affected: Resident #1 discharged to home. Completion date 04/03/2015 F.314 How corrective action will be accomplished for those residents with the potential to be affected by the same	4/3/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/30/2015

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 an abdominal fold. Review of the resident ' s most recent skin assessment dated 2/24/15 revealed the presence of a stage two pressure ulcer on the left and right gluteal fold, cellulitis below the knee on both legs, and excoriation of the abdomen under an abdominal fold. Review of the resident ' s physician orders for wound treatment dated 1/21/15 revealed orders to clean bilateral lower legs, apply nystatin powder, and wrap with Kerlix every three days. Orders for the left and right gluteal fold stage two pressure ulcers specify clean, pat dry, and apply Mediplex Ag dressing every three days. Review of the resident ' s February, 2015 Treatment Record revealed no entry for wound treatment to the left and right gluteal folds or the left and right lower extremities on the scheduled wound care dates of February 20th, February 23rd, or February 26th. Review of the resident ' s Nursing Progress Notes from February 20th to March 1st revealed no documentation of wound treatment provided by the nursing staff. An observation on 3/16/15 at 2:10 PM revealed wound care provided by Nurse # 1, the resident ' s first shift primary care nurse for the day. Nurse #1 was observed to use aseptic technique and to administer care according to the physician orders. Observation of the resident ' s skin revealed the wounds appeared as described in the most recent weekly assessment. Nurse # 1 stated she would document the provision of wound care on the Wound Treatment Log and in the progress notes. An interview on 3/16/15 at 2:30 PM with Resident #1 revealed his concern that wound care was not provided consistently every three days as ordered by his physician. Resident #1 stated he had not	F 314	practice: The DON and or designee will audit all Treatment records of residents with pressure ulcers and wounds to ensure accurate treatment daily Monday-Friday for 4 weeks, Bi-Weekly X 4 weeks, and weekly X 4 weeks. Results will be reviewed at weekly Quality Assurance Risk meeting for further problem resolution. The Staff Development coordinator will educate all current Licensed Nurses on Policy #3201 General Wound Care/Dressing Changes. Completion date is 04/03/2015 F.314 Measures in place to ensure practices will not re-occur: The DON and or designee will audit all Treatment records of residents with pressure ulcers and wounds to ensure accurate treatment daily Monday-Friday for 4 weeks, Bi-Weekly X 4 weeks, and weekly X 4 weeks. Results will be reviewed at weekly Quality Assurance Risk meeting for further problem resolution. All Licensed Nurse new hires will receive education on policy #3201 General Wound Care/Dressing Changes during orientation. Completion 04/03/2015 F.314 How the facility plans to monitor and ensure correction is achieved and sustained: Audit results will be reviewed at Quarterly Quality Assurance meeting X1 for any further problem resolution. Completion 04/03/2015	

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F 314	Continued From page 2	F 314		

been provided wound care on February 20th, 23rd, or 26th. He further stated that wound care " has been missed on other dates. " Resident #1 stated he was satisfied with the wound care that was being provided by the facility currently. He stated the facility ' s new Director of Nursing (DON) had spoken with him that morning and assured him that the facility would implement changes to insure consistent wound care was provided to all residents.

Review of the resident ' s Skin Risk/Weekly Assessments for February 2015 and March 2015 revealed documentation supporting improvement/healing of the resident ' s multiple wounds.

A telephone interview was conducted with Nurse #2 on 3/17/15 at 2:00 PM with the first shift nurse who provided primary care to the resident on February 20th, 23rd, and 26th. She stated she was familiar with the resident and his wound treatment orders. She further stated that she could not be certain that she provided the scheduled wound care to the resident on the three days in question. The nurse stated she recalled finding an outdated dressing on the resident ' s leg wounds and being upset because the date on the old dressing verified multiple dressing changes had been missed. She stated she did not remember the date of the occurrence. When asked if she was the person who should have performed the missed dressing changes she stated she did not know. She verified that the facility does not have a wound care nurse and that it is the responsibility of the first shift primary care nurse to provide ordered wound treatment to the residents assigned to their care. Nurse #2 stated that she would have been responsible for providing wound care to the resident if wound treatment was ordered when she was the

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F 314	Continued From page 3 resident ' s primary care nurse. When told that she was the nurse responsible for the resident ' s care on February 20th, 23rd, and 26th, she stated she did not recall whether or not she provided the ordered wound care. Review of all available documentation of the wound treatment for Resident #1 revealed no evidence that wound treatment was provided on February 20th, 23rd, or 26th. A telephone interview was conducted with Nurse #3, who worked with Resident #1 on February 23, 2015 while the resident was temporarily housed on her unit. Nurse #3 stated that the resident stayed on her unit, Magnolia Unit, on February 23rd due to the floors being repaired in the Independence Unit where Resident #1 lived. Nurse #3 stated that she had not provided wound care to the resident. She stated the resident was moved back to the Independence Unit after lunch on February 23rd. Nurse #3 stated she was not familiar with Resident #1 ' s wound treatment and assumed the primary care nurse on the Independence Unit would provide his wound treatment for February 23rd. Review of the nursing schedule for February 20, 2015 thru February 26, 2015 revealed Nurse #2 was scheduled as Resident #1 ' s primary care nurse on the Independence Unit for the period of time in which Resident #1 ' s wound care was not documented - February 20, 2015 thru February 26, 2015. An interview was conducted on 3/17/15 at 2:20 PM with the DON. The DON stated that it was her expectation that the first shift primary care nurse provide wound care to a resident as ordered by the physician. The DON stated even though it was her first week in the facility she recognized a problem with the administration of wound treatments to the residents. She further	F 314		

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F 314	Continued From page 4 stated that neither she nor the facility nurse consultant could find any documentation of wound treatment for Resident #1 on February 20th, 23rd, or 26th. An interview was conducted on 3/17/15 at 3:15 PM with the facility ' s Administrator. The Administrator stated that it was her expectation that wound care be provided to each resident by the first shift primary care nurse according to the physician ' s orders. She stated that due to the lack of wound care documentation for the dates of February 20th, 23rd, and 26th she would have to conclude that it was possible the ordered wound treatment was not provided.	F 314		