STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345404	A. BUILDING _____ B. WING _____	01/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE RIVERS HEALTH AND REHAB	1403 CONNER DRIVE WINDSOR, NC 27983

(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 staff and family interviews and record review, the facility failed to failed to place the orders for dressing changes to the left arm skin tear in the treatment book for 1 of 1 residents (Resident #40) reviewed for skin tears. Findings included: Resident #40 was admitted to the facility on 2/16/15 with diagnoses that included heart failure, hypertension, diabetes and history of skin cancer. The 11/25/15 Quarterly Minimum Data Set (MDS) indicated Resident #40 was cognitively intact with no refusal of care coded. The MDS identified Resident #40 as requiring extensive assistance with bed mobility, transfer, and personal hygiene. A Skin Tear Review, dated 12/12/15 indicated the resident had a new skin tear on his upper mid vertebrae. The narrative note indicated while the resident was being bathed staff noted blood from the resident's middle back that included an eraser sized scab that came off and started bleeding. A 12/25/15 Weekly Skin check indicated no new skin issues. The care plan for Resident #40 with an initiation date of 12/27/15, indicated the resident had skin tears to his arms with risk of complications such as poor healing or infection. Interventions to	F 309	Corrective Action for affected resident: Order obtained for treatment of skin tear for resident #40 on 12/29/15. Skin Tear assessed per protocol 12/29/2015 and weekly thereafter. Skin tears to left forearm were noted as healed with effective date of 1/18/2015. How the facility will identify other residents with potential to be affected: Every Skilled Nursing resident in our facility received a head to toe skin assessment by either the DON/RN, the MDSC/RN or the LPN Support/Wound Nurse between the dates of 1/15/16 – 1/21/16. Any noted breaks in skin integrity were matched to existing wound assessments. Any areas not previously assessed were assessed per protocol with appropriate physician orders obtained. Physician orders for existing wounds and skin tears were verified during the process. Measures put in place/Systemic changes to ensure practice does not recur: All nursing staff members were required to attend a mandatory inservice on	2/12/16

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

Electronically Signed | 02/05/2016

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F 309	Continued From page 1 prevent infection and poor healing included keeping his nails short to reduce the risk of scratching or injury from picking at his skin, protective arm coverings, report skin abnormalities and monitor/document location, size and treatment of the skin tear. A nurse's progress note, dated 12/28/15 at 12:58 AM indicated the resident's family member and Responsible Party (RP) visited on 12/27/15 at 7:00 PM. The family pointed out there was a noted odor coming from Resident #40's left forearm. The nurse documented family members removed geri-sleeves from the resident's arms and showed the nurse the sure-site (a type of transparent dressing) to the left forearm with yellowish drainage under the same. The nurse documented she cleaned the skin tear and measured it as 2 centimeters (cm) diameter. She applied antibiotic ointment and a non-stick dressing. The nurse also documented she had notified the physician of the left forearm skin tear and received orders to continue the dressing. Review of the December 2015 Treatment orders revealed a treatment begin date of 12/28/15 was documented for the left forearm skin tear. A physician's order was received on 12/29/15 to cleanse the skin tear to Resident #40's left arm with wound cleanser, approximate edges with steri-strips (Band-Aid like strips that secure a wound together) and leave the steri-strips in place until they came off. Orders also indicated the area was to be monitored daily. Orders for a skin tear to the lower left arm, started on 12/29/15 to cleanse the area with wound cleanser and apply triple antibiotic ointment daily until healed. The Responsible Party (RP) was interviewed on 1/12/16 at 10:58 AM. The RP stated on 12/27/15, she and another family member came to visit	F 309	protocols for weekly skin checks, skin tear assessments, wound assessments, physician orders for treatment of breaks in skin integrity and notification of Responsible Parties when breaks in skin integrity are noted. Weekly skin check schedules were reviewed for all SNF residents and Point Click Care was reviewed and updated to assure skin checks are “firing” to licensed nurses on a weekly basis. A “Change in Condition” form has been created and made available to all staff members on each hall of the SNF unit. Staff was trained on proper use of this form as a way to notify licensed nurses of changes in condition, refusal or resisting care or noted breaks in skin integrity. The completed form is presented to the licensed nurse and signed. The concern is addressed and recorded and completed form is submitted to the DON. The DON brings all submitted Change in Condition forms into daily QA meeting and verifies any noted issue has been properly addressed. Monitoring of Performance to assure solutions sustained: Nurse management team, which consists of DON/RN; MDSC/RN and LPN Support/Wound Nurse meet daily Monday – Friday and review all new skin tears and wounds as well as verify completion of assigned weekly skin checks. All wounds are verified to have existing and appropriate physician orders for treatment and treatments are verified present on Treatment Administration Record. LPN Support/Wound Nurse assesses all	

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F 309	Continued From page 2 Resident #40 and found the resident had odor. On removing the left geri-sleeve, the RP stated a skin tear on his arm that was covered with a clear dressing. Underneath the dressing was yellow drainage and odor. She stated it was reported to the nurse on duty who was Nurse #3. A telephone interview was held with Family Member (FM) #1 on 1/12/16 at 1:28 PM. FM #1 stated on 12/27/15, she and the RP visited and found the skin tear with yellow drainage and odor on Resident #40's left arm and reported it to the nurse on duty. An observation of Resident #40 was made on 1/12/16 at 1:40 PM. He was found sitting in the geri-chair in his room. Geri sleeves were observed bilaterally on the resident's arms. His nails were noted to be clean, but long, extending ¼ to ½ inch beyond the tip of the finger. Nursing Assistant (NA) #1 was interviewed on 1/12/16 at 2:26 PM. NA #1 described Resident #40 as alert and oriented. The NA stated if skin tears or other skin problems were found, the nurse was told. She added NAs had no place to document skin impairment. NA #1 stated Resident #40 sometimes received skin tears because he picks his skin and at times was combative during care. Interventions used to decrease the risk of skin tears included geri-sleeves that are only removed during care, wearing long sleeve shirts and moisturizing the skin. An interview was held with NA #2 on 1/12/16 at 2:45 PM. She stated she had not noticed Resident #40's fingernails and had not attempted to cut his nails. On 1/12/16 at 3:00 PM, Nurse #2 was interviewed. Nurse #2 observed Resident #40's and stated his nails needed trimming. She stated Resident #40 had multiple skin tears and the long	F 309	wounds including skin tears on a weekly basis. A weekly wound log is completed and presented weekly to QA team which includes Administrator for review. Monthly the LPN Support/Wound Nurse is responsible for presenting a wound log to the QA team which shows any trends in wounds/skin tears. Also monthly Nurse Management team reviews Treatment Administration Records to assure treatments are being provided to wounds consistently as ordered. Any concerns noted result in immediate retraining 1:1 and follow-up through QA Committee.	

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nails could increase the number of skin tears.
Nurse #1 was interviewed on 1/13/16 at 2:44 PM. She stated she had received in report on return to work on 12/28/15 that Resident #40's family members had found a skin tear during their visit on 12/27/15 that looked like it had "been there a while". The nurse added staff she spoke with were unaware of how the skin tear occurred.
During a wound observation on 1/13/16 at 3:11 PM, Resident #40 had one skin tear on his left arm with steri-strips in place. The resident stated he had hit his arm on something.
On 1/14/16 at 8:03 AM, Nurse #3 was interviewed. She acknowledged she had worked on 12/27/15 during the shift when Resident #40's family members visited. Nurse #1 stated one of the family members requested she go to the resident's room to observe a skin tear on the resident's left arm that had an odor and drainage. Nurse #3 stated on observation, she noticed yellow green drainage under the clear dressing. When she took the dressing off of Resident #40's left arm, there was an odor. She added she notified the physician, cleaned the skin tear and applied a new dressing. The nurse added she was unsure how the skin tear on Resident #40's left arm occurred. She stated an incident report was to be completed and she was unsure why one had not been completed for the left arm skin tear.
The Director of Nursing (DON) was interviewed on 1/14/16 at 8:27 AM. The DON stated there were standing orders for treatments of wounds. The nurse finding the wound was responsible for entering the standing order so the order was automatically generated on the electronic treatment record. Incident reports are needed for new skin tears to be completed by the nurse that found the skin tear. The DON reviewed the

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F 309	Continued From page 4 treatment sheets for December 2015 and acknowledged a treatment was not written for the left arm skin tear until after the family members reported the skin tear on 12/27/15. She stated she had no clue when the skin tear occurred, how it occurred or who initiated the treatment since an incident report had not been completed for the left arm skin tear. The DON stated interventions to decrease the risk of Resident #40's skin tears included geri-sleeves, skin moisturizers and long sleeves. The DON stated she spoke to Nurse #4 that completed the 12/25/15 skin check and denied Resident #40 had a skin tear on his left arm at that time. Nurse #4 was interviewed on 1/14/16 at 9:28 AM. She stated on 12/25/15 when she completed the skin assessment of Resident #40, he had no skin tears on his left arm. The Treatment Nurse (TN) was interviewed on 1/14/16 at 10:50 AM. She stated she was responsible for once a week measurements and documentation of wounds and not the day to day dressing changes. The TN stated she became aware of the skin tear on Resident #40's left arm when she returned to work on 12/28/15. She stated staff had not informed her of the skin tear, but she had heard about it from the family members. When the left arm skin tear was assessed on 12/28/15, there was no signs and symptoms of infection. The TN stated she had no clue when the skin tear occurred.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		2/12/16

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F 312	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to remove facial hair and trim fingernails for 1 of 1 resident (Resident #40) who required extensive assistance with personal hygiene and whose care was observed. Findings included: Resident #40 was admitted to the facility on 2/16/15 with diagnoses that included heart failure, hypertension and diabetes. The 11/25/15 Quarterly Minimum Data Set (MDS) indicated Resident #40 was cognitively intact. Refusal of care had not been identified. The MDS indicated Resident #40 required extensive assistance with personal hygiene. Resident #40 ' s care plan, revised on 1/12/16, revealed he required assistance with his activities of daily living and required his fingernails to be kept short to reduce the risk of skin tears. The care plan also instructed staff to report any refusals of care to the nurse in an attempt to determine the possible cause of the refusal. Under the tab "Tasks", in the electronic medical record (EMR) was the subcategory of grooming that included hair care, oral care, shaving, nail care and dressing to be completed by the nursing assistant (NA) or the nurse every shift. Nail care was to be given Tuesday and Friday evenings and as needed. Nail care was documented as given on 1/1/16 and 1/11/16 at 10:37 AM. Grooming including a shave was documented as given on 1/12/16 at 10:10 AM. An observation was made on 1/11/16 at 12:12 PM. Resident #40 had white facial hair present.	F 312	Corrective Action for affected resident: Resident #40 received a shower, was shaved and nails trimmed the evening of 1/12/2016. Resident has received showers at least weekly and been shaved daily since that date. Additionally, it has been verified by DON and Administrator on a daily basis that Resident #40 has received appropriate ADL assistance. How the facility will identify other residents with potential to be affected: Every Skilled Nursing resident in our facility received a head to toe skin assessment by either the DON/RN, the MDSC/RN or the LPN Support/Wound Nurse between the dates of 1/15/16 – 1/21/16. Any concerns with ADL assistance were immediately addressed. All patients/residents were verified to be clean shaven if indicated, bathed, and nails trimmed and clean. Measures put in place/Systemic changes to ensure practice does not recur: All nursing staff members were required to attend a mandatory inservice on protocols for appropriate Activities of Daily Living care for residents. Weekly shower/whirlpool schedules (which includes shampooing and nail care) for all SNF residents and Point Click Care was reviewed and updated to assure showers/whirlpools are “firing” to licensed nurses on a weekly basis. All nursing staff members are required to	

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F 312	Continued From page 6 His fingernails extended beyond the tip of his fingers approximately ¼ to ½ inch. An observation and interview was held with the resident on 1/12/16 at 1:40 PM. He was found sitting in the geri-chair in his room. Resident #40 had obvious white facial hair on his chin and cheeks. His fingernails extended 1/4 to 1/2 inch beyond the nail bed. The resident stated he had last received a shave on 1/10/16; adding he preferred to be shaven every other day. During care that morning (1/12/16), Resident #40 stated no one had offered to shave him or trim his nails. NA #1 was interviewed on 1/12/16 at 2:26 PM. She described Resident #40 as alert and oriented. The NA stated she had been assigned to care for Resident #40 that day. She added when giving care, if a resident refused, she was expected to ask the resident twice and then report the continued refusals to the nurse for documentation. The NA stated if grooming had been signed off in the EMR, that meant grooming, which included shaving and nail care had been completed. NA #1 reported she had no residents, including Resident #40 that has refused care that day. The NA added because of an early appointment, the night shift had bathed the resident, but she had not offered to shave him. The NA stated the resident is alert and oriented. The NA stated she had not charted on the resident this morning. When the EMR entry under Task was reviewed, the NA stated she had not charted Resident #40 ' s grooming had been completed. On 1/12/16 at 2:45 PM, NA #2 was interviewed. She acknowledged she had charted Resident #40 ' s grooming had been completed. The NA added she had attempted to shave the resident, but he fought her, so she stopped and reported the fighting and refusal to Nurse #2. She stated she	F 312	view “Bathing Without a Battle” produced by UNC by 2/12/206 Monitoring of Performance to assure solutions sustained: Every SNF resident is visually inspected by a member of the Nurse Management team Monday through Friday through performance of resident care rounds. These rounds are recorded on the “Nurse Management Rounds” audit form. Specific room numbers/residents are assigned to each of the 3 members of the management team and documentation of their rounds verifying appropriate ADL care is brought into daily QA meeting the following day and reviewed by QA team and Administrator for completion. Any trends or concerns are addressed immediately through 1:1 retraining with staff member responsible for the noted resident’s ADL assistance/care.	

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had not noticed Resident #40 ' s long fingernails and had not attempted to cut his nails.
Nurse #2 was interviewed on 1/12/16 at 2:58 PM. She stated NA #2 had not reported an attempt to complete grooming, fighting or refusal of care for Resident #40. The nurse stated she was unaware the resident refused care.
An observation of Resident #40 was made on 1/12/16 at 3:00 PM with Nurse #2. She stated she typically worked the hall where Resident #40 lived and was unaware he refused care. The nurse added if a resident refused care, the NA was expected to report the refusal to her so charting can be completed. NAs were not expected to document care was given prior to giving the care. Nurse #2 observed Resident #40 and stated his nails needed trimming; adding that because Resident #40 had diabetes, she was expected to trim his fingernails. The nurse stated she had not noticed his long nails and added his long fingernails increased his chance of sustaining skin tears. Nurse #2 acknowledged Resident #40 needed to be shaved and when she asked him if he wanted to be shaved, he answered yes.
The Director of Nursing (DON) was interviewed on 1/13/16 at 4:21 PM. She stated her expectation was for nail care to be completed weekly and shaves twice a week on shower days and as needed. The expectation was for NAs to document the provision of care after the task was completed and not prior to completion. The DON added if a resident refused to be groomed, the NA was expected to notify the nurse. The DON stated she had been not been aware Resident #40 had any behaviors, including refusal of care at times, until yesterday. She stated she had noted white facial hair on his chin but had not noticed his long fingernails.

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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, interviews with staff and family members and record review, the facility failed to identify pressure areas to the resident ' s heels and failed to immediately initiate treatment for 1 of 3 sampled residents (Resident #40) reviewed for pressure ulcers. Findings included: Resident #40 was admitted to the facility on 2/16/15 with diagnoses that included heart failure, hypertension and diabetes. The 11/25/15 Quarterly Minimum Data Set (MDS) indicated Resident #40 was cognitively intact with no refusal of care identified. The MDS noted the resident required extensive assistance with bed mobility, transfer and personal hygiene. Limitation in functional range of motion was coded for one side of his lower extremities. Resident #40 had been identified as being at risk for pressure ulcers, but at the time of the assessment had no pressure ulcers. Review of Pressure Ulcer documentation, dated 12/28/15, indicated on 12/26/15 a suspected deep tissue injury (SDTI) was found on Resident #40's right heel measuring 3 centimeters (cms)	F 314	Corrective Action for affected resident: Order obtained for treatment of pressure areas on heels for resident #40 on 12/28/2015. Orders verified as on Treatment Administration Record 1/12/2016. How the facility will identify other residents with potential to be affected: Every Skilled Nursing resident in our facility received a head to toe skin assessment by either the DON/RN, the MDSC/RN or the LPN Support/Wound Nurse between the dates of 1/15/16 – 1/21/16. Any noted pressure areas or breaks in skin integrity were matched to existing wound assessments. Any areas not previously assessed were assessed per protocol with appropriate physician orders obtained Physician orders for existing wounds and skin tears were verified during the process. . All orders were verified on Treatment Administration Record. Measures put in place/Systemic changes	2/12/16

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F 314	Continued From page 9 by (x) 2.5 cms. The area was described as red and boggy. Skin prep and podus boot (a specialized type of boot used to relive pressure) was applied. A physician's order was received on 12/28/15 to cleanse Resident #40's right heel with wound cleanser and apply skin prep to the red boggy area twice daily until healed. A nurse's progress note, written by Nurse #3 and dated 12/28/15 at 12:58 AM indicated the resident's family members visited on 12/27/15 at 7:00 PM. The family pointed out a hard area to the left heel. The nurse documented she notified the physician and received orders to off load the resident's heels and monitor the area. On 12/28/15, the pressure ulcer record indicated Pressure ulcer #2 was identified as 3.5 cms x 6 cms with an onset date of 12/28/15. The area was described as an SDTI that was dark red, black and boggy on the left heel. Review of the treatment sheet for December 2015 revealed no orders for the treatment of Resident #40's left heel pressure ulcer. Resident #40's care plan with an initiation date of 12/29/15 indicated he was at risk of pressure ulcers and had actual pressure ulcers to his heels. Interventions included assessing, recording and monitoring wound healing weekly including measurements of length, width and depth when possible. Nurse Aides (NAs) were directed to report any redness, open areas or skin irritation to the nurse immediately. The Responsible Party (RP) was interviewed on 1/12/16 at 10:58 AM. The RP stated on 12/27/15, she and Family Member (FM) #1 visited Resident #40 and looked at the resident's foot and found a blackened area on the left heel. The RP added NA #1 had told her, she reported the change in Resident #40's heel to Nurse #4 and the	F 314	to ensure practice does not recur: All nursing staff members were required to attend a mandatory inservice on protocols for weekly skin checks, skin tear assessments, wound assessments, physician orders for treatment of pressure areas and breaks in skin integrity and notification of Responsible Parties when pressure areas or breaks in skin integrity are noted. Weekly skin check schedules were reviewed for all SNF residents and Point Click Care was reviewed and updated to assure skin checks are “firing” to licensed nurses on a weekly basis. A “Change in Condition” form has been created and made available to all staff members on each hall of the SNF unit. Staff was trained on proper use of this form as a way to notify licensed nurses of changes in condition, refusal or resisting care, pressure areas or noted breaks in skin integrity. The completed form is presented to the licensed nurse and signed. The concern is addressed and recorded and completed form is submitted to the DON. The DON brings all submitted Change in Condition forms into daily QA meeting and verifies any noted issue has been properly addressed. Monitoring of Performance to assure solutions sustained: The Nurse management team, which consists of DON/RN; MDSC/RN and LPN Support/Wound Nurse meet daily Monday – Friday and review all new skin tears and wounds as well as verify completion of assigned weekly skin checks. All pressure	

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F 314	Continued From page 10 Treatment Nurse (TN) a week and a half prior to the family's discovery. A telephone interview was held with FM #1 on 1/12/16 at 1:28 PM. She stated when she and the RP visited on 12/27/15, they found a left heel pressure ulcer on Resident #40 and reported it to the nurse on duty at the time. The nurse told the FM and the RP she had been unaware of a left heel pressure ulcer. Review of the January 2015 Treatment Record indicated there had been no treatment entry or documentation of a treatment for Resident #40's left heel pressure ulcer until 1/12/16. During a wound care observation on 1/13/16 at 2:15 PM with the TN, Resident #40's left heel pressure ulcer was observed to be 4 cm x 5.5 cm. The TN described the pressure ulcer as a dark, red/black DTI. The treatment was skin prep. She further described the pressure ulcer as 5% boggy. The right heel pressure ulcer measured 4 cms by 2.5 cms with hard tissue that the TN described as a DTI. NA #1 was interviewed on 1/12/16 at 2:26 PM. The NA stated about a month or so ago, she had noticed an area to the top of the resident's right foot and had reported it to the nurse. When she had worked on 12/24/15 she had noticed a red spot on Resident #40's left heel and stated she had told a nurse. The nurse, whose name she could not remember, told her she had already reported the reddened area to the treatment nurse. Nurse #1 was interviewed on 1/13/16 at 2:44 PM. Nurse #1 stated she had received in report the morning of 12/28/15 that Resident #40's family had found pressure ulcers on the resident's heels. Prior to 12/28/15, the nurse stated she had no knowledge of pressure ulcers on the resident's heels.	F 314	areas and wounds are verified to have existing and appropriate physician orders for treatment and treatments are verified present on Treatment Administration Record. LPN Support/Wound Nurse assesses all wounds including pressure areas and skin tears on a weekly basis. A weekly wound log is completed and presented weekly to QA team which includes Administrator for review. Monthly the LPN Support/Wound Nurse is responsible for presenting a wound log to the QA team which shows any trends in wounds/skin tears. Also monthly Nurse Management team reviews Treatment Administration Records to assure treatments are being provided to pressure areas and wounds consistently as ordered. Any concerns noted result in immediate retraining 1:1 and follow-up through QA Committee	

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F 314	Continued From page 11	F 314		

On 1/14/16 at 8:03 AM, Nurse #3 was interviewed. She acknowledged she was the nurse working on 12/27/15 when Resident #40's FM #1 and RP came to visit. She stated the family members asked her to go to the resident's room where she saw an area on the left heel that appeared as a quarter sized hard, flesh colored area. She stated the physician was notified and ordered the heels to be floated. Nurse #3 stated she had been unaware of the pressure ulcer on the resident's right heel with an onset date of 12/26/15. The nurse stated standing orders were to be used for treatment. Those orders would be entered into the electronic medical record (EMR) to be automatically generated to the treatment sheet. Nurse #3 had no reason why the order for the left heel pressure ulcer had not been entered into the EMR.

The Director of Nursing (DON) was interviewed on 1/14/16 at 8:27 AM. She stated the facility used standing orders for pressure ulcer care. She added the nurse that found the pressure ulcer was expected to complete the first assessment and communicate the wound via the EMR Communication Board. The DON stated when Nurse #3 became aware of the left heel pressure ulcer for Resident #40, she notified the physician and followed the physician orders. She stated the information about the pressure ulcer should have been passed on in report and added to the treatment sheet so staff could continue to monitor the pressure area on the left heel. The DON reviewed the December 2015 treatment sheet and the January 2016 treatment sheet and acknowledged monitoring or treatment of the left heel pressure ulcer had not started until 1/12/15 when she assessed the left heel pressure ulcer. She added while there was no previous order for the left heel pressure ulcers, she

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F 314	Continued From page 12	F 314		

believed staff had been using the same treatment the wound clinic had ordered for the right heel pressure ulcer. Review of protocol/standing orders for wounds did not identify triple antibiotic ointment as an acceptable treatment for a SDTI. She stated it was beyond the scope of practice for a nurse to determine the treatment plan and the physician should have been made aware of the ulcer and any change in treatment. The DON stated when a NA observed any change in a resident's skin condition, they are expected to report that to the nurse immediately.

Nurse #4 was interviewed on 1/14/16 at 9:28 AM. She stated she had completed the skin assessment for Resident #40 on 12/25/15 and no pressure areas were seen on either heel. She denied receiving reports from NA #1 or any other NA, about any reddened areas on the resident's heels.

On 1/14/16 at 9:43 AM a telephone interview was held with NA #3. She stated she had worked with the resident on 12/27/15 for the 7:00 AM to 7:00 PM shift. She stated she had observed a red purple area on Resident #40's left heel that was about the size a quarter or 50 cent piece. The NA was unsure if she had seen the area before, but stated there had been no dressing in place during her shift on 12/27/15. The NA stated she had reported the area to Nurse #4, who told her she would tell the treatment nurse.

Nurse #2 was interviewed by phone on 1/14/16 at 10:00 AM. She stated she had worked on 12/24/15 with Resident #40 during the 7:00 AM to 7:00 PM shift. Nurse #2 denied receiving any reports of a reddened area to the resident's left heel on 12/24/15 and had been unaware of the area before 12/27/15.

On 1/14/16 at 10:50 AM, the Treatment Nurse was interviewed with the DON present. She

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F 314	Continued From page 13 stated any pressure ulcer found on weekends, nights or any other time she was not working was placed on the EMR communication board. She would then assess the pressure ulcers. Even when she was not working, the TN stated all new wounds found were to be assessed and treatment started immediately using the facility's wound protocols. When a nurse used a wound protocol, the nurse was expected to enter the standing order into the EMR for automatic transferal to the treatment sheet. The TN stated she became aware of the left heel wound on 12/28/15 when she returned to work and looked at the communication board; adding she then assessed the wound and made sure a treatment had been placed. On assessment, she found Resident #40's left heel boggy and red with measurements of 3.5 cms x 6.0 cms. The treatment of choice was skin prep to be applied daily. The TN stated she would have entered the order into the EMR so it would be generated on the treatment sheet. She then reviewed the treatment sheets for December 2015 and January 2016 and acknowledged the treatment for the left heel was not included. The TN stated it must have been an oversight on her part and without the entry, nurses would not have known what treatment or even to treat Resident #40's left heel pressure ulcer. The DON interjected and stated without the order entered into the electronic system, it would not have been captured as an omission during end of the month order reconciliation. The TN denied having known about the left heel pressure ulcer prior to 12/28/15.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		2/12/16

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F 323	Continued From page 14 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff and family interviews and record review, the facility failed to determine the root cause of a left arm skin tear and failed to follow the care plan interventions for prevention of skin tears for 1 of 1 residents (Resident #40) reviewed for skin tears. Findings included: Resident #40 was admitted to the facility on 2/16/15 with diagnoses that included heart failure, hypertension, diabetes and history of skin cancer. The 11/25/15 Quarterly Minimum Data Set (MDS) indicated Resident #40 was cognitively intact with no refusal of care coded. The MDS identified Resident #40 as requiring extensive assistance with bed mobility, transfer, and personal hygiene. A Skin Tear Review, dated 12/12/15 indicated Resident #40 had a new skin tear on his upper mid vertebrae. The narrative note indicated while the resident was being bathed staff noted blood from the resident's middle back that included an eraser sized scab that came off and started bleeding. A 12/25/15 Weekly Skin check indicated no new skin issues. The care plan for Resident #40 with an initiation date of 12/27/15, indicated the resident had skin tears to his arms with risk of complications such as poor healing or infection. Interventions to	F 323	Corrective Action for affected resident: Resident #40 received a shower, was shaved and nails trimmed the evening of 1/12/2016. Resident has received showers at least weekly or received a bed bath which includes nail care since that date. Additionally, it has been verified by DON and Administrator on a daily basis that Resident #40 has received appropriate ADL assistance and nails have been inspected to assure they are neatly trimmed. Incident Report for skin tear noted was reviewed and root cause analysis recorded as unaddressed resisting care behaviors resulting in untrimmed nails. Determination of root cause resulted in creation of a “Patient Change Alert” sheet to improve communication of both behaviors and noted breaks in skin integrity. Resident #40’s care plan was reviewed by interdisciplinary care planning team and verified as accurate. Care plan measures were verified as being transmitted to direct care staff per protocol. How the facility will identify other residents with potential to be affected:	

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F 323	Continued From page 15 prevent infection and poor healing included keeping his nails short to reduce the risk of scratching or injury from picking at his skin, protective arm coverings, report skin abnormalities and monitor/document location, size and treatment of the skin tear. A nurse's progress note, dated 12/28/15 at 12:58 AM indicated Resident #40's family member and Responsible Party (RP) visited on 12/27/15 at 7:00 PM. The family pointed out there was a noted odor coming from Resident #40's left forearm. The nurse documented family members removed geri-sleeves from the resident's arms and showed the nurse the sure-site (a type of transparent dressing) to the left forearm with yellowish drainage under the same. The nurse documented she cleaned the skin tear and measured it as 2 centimeters (cm) diameter. She applied antibiotic ointment and a non-stick dressing. The nurse also documented she had notified the physician of the left forearm skin tear and received orders to continue the dressing. Review of the December 2015 Treatment orders revealed a treatment begin date of 12/28/15 was documented for Resident #40's left forearm skin tear. A physician's order was received on 12/29/15 to cleanse the skin tear to Resident #40's left arm with wound cleanser, approximate edges with steri-strips (Band-Aid like strips that secure a wound together) and leave the steri-strips in place until they came off. Orders also indicated the area was to be monitored daily. Orders for a skin tear to the lower left arm, started on 12/29/15 to cleanse the area with wound cleanser and apply triple antibiotic ointment daily until healed. The Responsible Party (RP) was interviewed on 1/12/16 at 10:58 AM. The RP stated on 12/27/15,	F 323	Every Skilled Nursing resident in our facility received a head to toe skin assessment by either the DON/RN, the MDSC/RN or the LPN Support/Wound Nurse between the dates of 1/15/16 – 1/21/16. All patients' nails were verified trimmed and smooth to prevent skin injuries related to scratching. Care plans for ADL dependent residents were reviewed as current and appropriate to meet needs and also assured to be properly transmitted to direct care staff. Measures put in place/Systemic changes to ensure practice does not recur: All nursing staff members were required to attend a mandatory inservice on protocols for appropriate Activities of Daily Living care for residents. This inservice also included review of procedure for reviewing resident care plans and the requirement that nursing staff be familiar with each resident's plan of care to assure documented measures are being followed. All incident/accident reports are brought into daily QA meeting by Director of Nursing to assure root cause analysis has been completed with discussion of root cause and actions taken to address to reduce likelihood of recurrence in affected resident and/or others. Weekly shower/whirlpool schedules (which includes shampooing and nail care) for all SNF residents and Point Click Care was reviewed and updated to assure showers/whirlpools are "firing" to licensed nurses on a weekly basis. All nursing staff members are required to view "Bathing Without a Battle" produced	

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F 323	Continued From page 16 she and another family member came to visit Resident #40 and found the resident had odor. On removing the left geri-sleeve, the RP stated a skin tear, on his left arm, was covered with a clear dressing. Underneath the dressing was yellow drainage and odor. She stated it was reported to the nurse on duty who was Nurse #3. A telephone interview was held with Family Member (FM) #1 on 1/12/16 at 1:28 PM. FM #1 stated on 12/27/15, she and the RP visited and found the skin tear with yellow drainage and odor on Resident #40's left arm and reported it to the nurse on duty. An observation of Resident #40 was made on 1/12/16 at 1:40 PM. He was found sitting in the geri-chair in his room. Geri sleeves were observed bilaterally on the resident ' s arms. His nails were noted to be clean, but long, extending ¼ to ½ inch beyond the tip of the finger. Nursing Assistant (NA) #1 was interviewed on 1/12/16 at 2:26 PM. NA #1 described Resident #40 as alert and oriented. The NA stated if skin tears or other skin problems were found, the nurse was told. She added NAs had no place to document skin impairment. NA #1 stated Resident #40 sometimes received skin tears because he picks his skin and at times was combative during care. Interventions used to decrease the risk of skin tears included geri-sleeves that are only removed during care, wearing long sleeve shirts and moisturizing the skin. An interview was held with NA #2 on 1/12/16 at 2:45 PM. She stated she had not noticed Resident #40's fingernails and had not attempted to cut his nails. On 1/12/16 at 3:00 PM, Nurse #2 was interviewed. Nurse #2 observed Resident #40's and stated his nails needed trimming. She stated	F 323	by UNC by 2/11/206. A “Patient Change Alert” form has been created and made available to all staff members on each hall of the SNF unit. Staff was trained on proper use of this form as a way to notify licensed nurses of changes in condition, refusal or resisting care, pressure areas or noted breaks in skin integrity. The completed form is presented to the licensed nurse and signed. The concern is addressed and recorded and completed form is submitted to the DON. Any refusal of care in provision of ADL’s is immediately addressed by the Nurse Management team to assure all documented care plan measures are being addressed. The DON brings all submitted Change in Condition forms into daily QA meeting and verifies any noted issue has been properly addressed. Monitoring of Performance to assure solutions sustained: Every SNF resident is visually inspected by a member of the Nurse Management team Monday through Friday through performance of resident care rounds. Specific room numbers/residents are assigned to each of the 3 members of the management team and documentation of their rounds verifying appropriate ADL care, which includes nail care, has been provided is brought into daily QA meeting the following day and reviewed by QA team and Administrator for completion. Any trends or concerns are addressed immediately through 1:1 retraining with staff member responsible for the noted resident’s ADL assistance/care.	

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F 323	Continued From page 17 Resident #40 had multiple skin tears and the long nails could increase the number of skin tears. Nurse #1 was interviewed on 1/13/16 at 2:44 PM. She stated she had received in report on return to work on 12/28/15 that Resident #40's family members had found a skin tear during their visit on 12/27/15 that looked like it had "been there a while". The nurse added staff she spoke with were unaware of how the skin tear occurred. During a wound observation on 1/13/16 at 3:11 PM, Resident #40 had one skin tear on his left arm with steri-strips in place. The resident stated he had hit his arm on something. On 1/14/16 at 8:03 AM, Nurse #3 was interviewed. She acknowledged she had worked on 12/27/15 during the shift when Resident #40's family members visited. Nurse #1 stated one of the family members requested she go to the resident's room to observe a skin tear on the resident's left arm that had an odor and drainage. Nurse #3 stated on observation, she noticed yellow green drainage under the clear dressing. When she took the dressing off of Resident #40's left arm, there was an odor. She added she notified the physician, cleaned the skin tear and applied a new dressing. The nurse added she was unsure how the skin tear on Resident #40's left arm occurred. She stated an incident report was to be completed and she was unsure why one had not been completed for the left arm skin tear. The Director of Nursing (DON) was interviewed on 1/14/16 at 8:27 AM. The DON stated there were standing orders for treatments of wounds. The nurse finding the wound was responsible for entering the standing order so the order was automatically generated on the electronic treatment record. Incident reports are needed for new skin tears to be completed by the nurse that	F 323	As per RAI protocols each resident's care plan is reviewed by our interdisciplinary care planning team to assure it remains accurate and appropriate to meet each resident's individual care needs. All incident/accident reports are reviewed by QA team daily M-F to assure root cause analysis has been completed and root cause addressed.	

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F 323	Continued From page 18 found the skin tear. The DON reviewed the treatment sheets for December 2015 and acknowledged a treatment was not written for the left arm skin tear until after the family members reported the skin tear on 12/27/15. She stated she had no clue when the skin tear occurred, how it occurred or who initiated the treatment since an incident report had not been completed for the left arm skin tear. The DON stated interventions to decrease the risk of Resident #40's skin tears included geri-sleeves, skin moisturizers and long sleeves. The DON stated she spoke to Nurse #4 that completed the 12/25/15 skin check and denied Resident #40 had a skin tear on his left arm at that time. Nurse #4 was interviewed on 1/14/16 at 9:28 AM. She stated on 12/25/15 when she completed the skin assessment of Resident #40, he had no skin tears on his left arm. The Treatment Nurse (TN) was interviewed on 1/14/16 at 10:50 AM. She stated she was responsible for once a week measurements and documentation of wounds and not the day to day dressing changes. The TN stated she became aware of the skin tear on Resident #40's left arm when she returned to work on 12/28/15. She stated staff had not informed her of the skin tear, but she had heard about it from the family members. When the left arm skin tear was assessed on 12/28/15, there was no signs and symptoms of infection. The TN stated she had no clue when the skin tear occurred.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332		2/12/16

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F 332	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to ensure the medication error rate was less than 5% as evidenced by 2 medication errors out of 27 opportunities resulting in a medication error rate of 7.4% for 1 of 4 residents (Resident #41) observed for medication administration. The findings included: Resident #41 was admitted 9/22/15 with diagnoses which included hypertension and malaise. Her most recent quarterly Minimum Data Set (MDS) dated 12/29/15 indicated she was cognitively intact. Review of Resident #41's current January 2016 physician's orders revealed an order for Losartan Potassium 100 milligrams to be given daily at 9:00 AM. Further review of the physician's orders revealed the resident had an order to receive 10 milliequivalents (mEq) of Potassium Chloride at 9:00 PM. On 1/13/16 at 8:37 AM Nurse #1 was observed giving medications to Resident #41. Nurse #1 administered Potassium Chloride 10 mEq to Resident #41 by mouth. Nurse #1 did not administer Losartan Potassium to Resident #41 at this time. On 1/13/16 at 11:14 AM an interview was conducted with Nurse #1. She stated she mistakenly administered Potassium Chloride instead of Losartan Potassium to Resident #41 during the morning of 01/13/16. Nurse #1 also stated that Resident #41 should not have received Potassium Chloride until 9:00 PM. She indicated she would discuss this with her Director of Nursing (DON) to ensure no other mistakes	F 332	Corrective Action for affected resident: Physician was notified immediately by nurse #1 regarding medication error and orders obtained. Responsible party of Resident #41 was notified as well per protocol. Resident #41 did not suffer adverse reactions related to medication error as documented over subsequent 3 day period. How the facility will identify other residents with potential to be affected: This medication error was specific to Resident #41. The potential for other residents to be affected by similar medication errors is being addressed through re-training of staff on “7 Rights of Medication Administration”. Measures put in place/Systemic changes to ensure practice does not recur: All nursing staff involved in the process of medication administration will receive 1:1 retraining and review by a member of the Nurse Management Team by 2/12/2016. Specifically Nurse #1 was re-trained by Director of Nursing regarding the “7 Rights of Medication Administration” on 1/14/2016. Monitoring of Performance to assure solutions sustained: The Nurse Management team will complete a medication pass audit on each nursing staff member involved in medication administration by 2/12/2016 using the CMS20056 QIS Survey Form. These audits will be repeated monthly	

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F 332	Continued From page 20 were made. An interview was conducted with the DON on 1/14/16 at 11:35 AM. She stated she expected the staff to give the proper medication to the proper resident at the proper time. She also stated the staff is expected to notify her, the physician, and the family when medication errors occur. An interview was conducted with the Administrator on 1/14/16 at 11:40 AM. She stated she expected the staff to follow the Five Rights (right patient, right drug, right dose, right route, and right time) for all medication administration.	F 332	over the next 12 months on each staff member involved in medication administration. Monthly during our consultant pharmacist's clinical audit she will complete 1-2 medication pass audits utilizing the CMS20056 and report findings to the DON. The DON in turn will include these findings with the Nurse Management team's findings during monthly Quality of Life. Audits will be submitted during monthly Quality of Life QA meeting. Concerns will be addressed immediately by 1:1 retraining.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.	F 356		2/12/16

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	345404	A. BUILDING _____ B. WING _____	01/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE RIVERS HEALTH AND REHAB	1403 CONNER DRIVE WINDSOR, NC 27983

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F 356	Continued From page 21 The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to post staffing data for 2 of 4 days, and failed to post accurate nursing staffing data for 2 of 4 days of the annual re-certification survey conducted from 1/11/16 to 1/14/16. The findings included: Observation of staffing data posted on 1/11/2016 and 1/12/2016 revealed Registered Nurse (RN) staff coverage for 24 hours each day. An interview was conducted with the Director of Nursing (DON) on 1/13/2016 at 9:32 AM. The DON explained the staff postings for 1/11/2016 and 1/12/2016 were incorrect because the RN staff coverage occurred only on the 7 PM to 7 AM shift and not the full 24 hours. The night nurse who filled out the staffing sheet had counted the DON as RN staff during the 7 AM to 7 PM shift. Observations on 1/13/2016 for staff posting were made at 11:34 AM, 2:59 PM, and 4:32 PM. The staff posting sheet was not seen. Observations on 1/14/2016 at 8:23 AM and 9:45 AM revealed no staff posting. An interview was conducted with the DON on 1/14/2015 at 9:54 AM. The DON stated she had forgotten to put out the staffing sheet for the last 2 days.	F 356	Corrective Action for affected resident: No residents were adversely affected by this noted deficiency. How the facility will identify other residents with potential to be affected: Other residents were not at risk or potentially affected by this noted deficiency. Measures put in place/Systemic changes to ensure practice does not recur: All licensed nurses involved in completion of the Daily Staffing Form received 1:1 retraining by the Director of Nursing. Covered in the training is proper completion of the form as well as the requirement that it be posted daily. All new licensed nurses will also receive 1:1 training by the Director of Nursing regarding proper completion of the Daily Staffing Form, including requirement to post daily as part of the New Employee Orientation process. Monitoring of Performance to assure solutions sustained: Daily Staffing Forms are checked each morning Monday-Friday by Nurse	

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F 356	Continued From page 22	F 356	Management Team to assure completion, posting and accuracy. Daily Staffing Forms are then brought into morning QA meeting for review and then kept in a notebook by the DON for reference. Any noted needs for retraining are addressed immediately and noted by DON.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain the temperature of the meat loaf at or above 135 degrees during the operation of the tray line. The findings included: On 1/13/15 at 11:50 AM Cook #1 used a calibrated thermometer to obtain the temperatures of the food items on the tray line. The food items including the pan of meat loaf registered 140 degrees or higher when the tray line started. On 1/13/16 at 12:25 PM Cook #1 obtained a second pan of meat loaf from the oven. She then placed a serving of the meat loaf onto each of 3 plates along with the other food items. She did	F 371	Corrective Action for affected resident: No residents were adversely affected by this deficient practice How the facility will identify other residents with potential to be affected: Residents throughout facility were monitored over 72 hours following the noted deficient practice for signs of foodborne illnesses. No such illnesses were noted. Measures put in place/Systemic changes to ensure practice does not recur: Cook #1 was immediately retrained on food temperatures and holding	2/12/16

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F 371	Continued From page 23 not take the temperature of the meat loaf prior to plating it. Upon request, the Dietary Manager using the calibrated thermometer obtained the temperature of the meat loaf on the tray line. It registered 100 degrees. The Dietary Manager then removed that pan of meat loaf and replaced it with a third pan of meat loaf. The Dietary Manager obtained the temperature of the third pan of meat loaf which registered 105 degrees. The tray line was stopped. The Dietary Manager returned pans of meat loaf to oven for reheating. On 1/13/16 at 2:11 PM Cook #1 stated she had cooked the meat loaf to 165 degrees in the convection oven prior to placing it in the small oven which she used for holding the meat until it was needed on the tray line. She stated she had placed the meat loaf in the small holding oven at 11:35 AM. She stated she did not know what the temperature of the oven was. On 1/13/16 at 4:14 PM the Dietary Manager stated Cook #1 had stored the pans of meat loaf in the stove top oven (small holding oven). She stated the thermostat on the oven was not up high enough. She stated she was unsure what the best holding temperature should be. She stated the second pan of meat loaf was not hot enough so she placed it back into the convection oven to rewarm it. She stated the nursing home population were susceptible to bacterial infections if food was not maintained at the correct temperature. On 1/14/16 at 11:23 AM the Administrator stated Cook #1 told her she did not realize the oven was not hot enough to keep the meat loaf hot. She also stated the Dietary Manager told her about the meat loaf temperature not being hot enough because the meat loaf was not in an oven hot enough to keep it at the proper holding temperature.	F 371	temperatures by corporate Dietary Consultant onsite during survey. All other dietary staff members were retrained by the Dietary Manager on 1/20/2016 regarding proper food temperatures and maintaining “Holding” temperatures in food being served. Monitoring of Performance to assure solutions sustained: Dietary Quality Assurance Audit was created by Registered Dietician and Dietary Consultant. The Audit includes food temperatures and holding temperatures as well as proper maintenance of the steam table. Audits are verified for completion by the Dietary Manager Mon-Friday and presented to the QA Committee monthly. Any concerns are addressed immediately through 1:1 retraining.	

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F 371	Continued From page 24 On 1/14/16 at 12:24 PM the Administrator stated she expected foods including meat loaf to be served at the proper temperature.	F 371		