PRINTED: 09/01/2016 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |         |   | (X3) DATE SURVEY<br>COMPLETED   |                       |                            |
|--|---|---|---------|---|---|-----------------------|----------------------------|
|  |   | 345144  | B. WING |   |   |                       | 28/2016                    |
| NAME OF P  | ROVIDER OR SUPPLIER   | <u> </u>  |         |   | STREET ADDRESS, CITY, STATE, ZIP CODE   | 077                   | 20/2010                    |
|  |   |   |         | 7   | 706 PINEYWOOD ROAD  |                       |                            |
| PINE RIDO  | GE HEALTH AND REHAB   | SILITATION CENTER   |         |   | THOMASVILLE, NC 27360   |                       |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   |         | PREFIX (EACH CORRECTIVE ACTION SHO<br>TAG CROSS-REFERENCED TO THE APP |   |                       | (X5)<br>COMPLETION<br>DATE |
|  |   |   |         |   | DEFICIENCY)   |                       |                            |
| F 224<br>SS=G  | ` '   | GLECT/MISAPPROPRIATN  | F       | 224   |   |                       | 8/22/16                    |
|  | policies and procedur   | , and abuse of residents  |         |   |   |                       |                            |
|  | by: Based on record reviphysician interviews to provide skin assessment reatment of a pressure admission, and the working and | ound progressed to an with necrosis for 1 of 3 2), reviewed for pressure  : hitted on 6/16/2016 with chronic kidney disease, as and type II diabetes. sessment was completed by n 6/26/2016, which noted a cossible opening on the ments or staging were noted hum Data Set (MDS) and the dated 6/29/2016 indicated ge 2 pressure ulcer, with esent on admission. Solan dated 7/6/2016 and #2 had a pressure ulcer. It turning and positioning, |         |   | F224 Neglect/Abuse/Miappropriation  What measures did the facility put in pla for the resident affected:  On 7/26/2016 resident #2□s wound wassessed by the MDS Coordinator. On 7/26/2016 a referral was made to the wound doctor by the MDS Coordinator. On 7/28/2016 a wound ulcer flow shee was completed by the treatment nurse. Resident #2 was seen by wound doctor on 7/28/2016. New treatment orders we received by the wound doctor. On 7/28/2016 the resident RP was made aware of condition of wound and new orders received by the DON. On 7/28/2016 the new orders were transcribed to resident #2□s TAR and initiated. On 7/28/2016 an air mattress was applied to resident #2 had a Foley catheter placed by staff nurse per | vas<br>et<br>r<br>ere |                            |
|  | supplements as order  | rea, and weekly wound   |         |   | catneter placed by staff nurse per  |                       |                            |
| ADODATODY  |   | SLIPPI IER REPRESENTATIVE'S SIGNATURE   |         |   | TITI F  |                       | (X6) DATE                  |

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

( - /

08/22/2016

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.

**Electronically Signed** 

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   |  | (X3) DATE SURVEY<br>COMPLETED         |  |
|--|---|--|---|--|---------------------------------------|--|
|  |   | 7 5                                    |   |  | С                                     |  |
|  | 345144  | B. WING                                |   |  | 07/28/2016                            |  |
| NAME OF PROVIDER OR SUPPLIER   |   |  | STREET ADDRESS, CITY, STATE, ZIP CO   | DE   | , 00                                  |  |
|  |   |  | 706 PINEYWOOD ROAD  |  |                                       |  |
| PINE RIDGE HEALTH AND REHAE  | SILITATION CENTER   |  | THOMASVILLE, NC 27360   |  |                                       |  |
| PREFIX (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG                     | PROVIDER'S PLAN OF C<br>X (EACH CORRECTIVE ACTIVE<br>CROSS-REFERENCED TO THE<br>DEFICIENCY  | ON SHOULD BE<br>HE APPROPRIA   |                                       |  |
| starting on 7/9/2016 a was to be applied even no area was identified staging or measurem. Another treatment was apply a tegaderm drea a busted blister on the Further review of this treatment for a stage (cm) x 3 cm x 1 cm to to clean with normal shydrogel dressing staprevious dressing for discontinued at this ticare physician to evantime. Treatments we completed.  A review of the nursimplan wound note date the MDS nurse, which pressure ulcer with more compositive to determ the wound was circul covering the entire what issue was sensitive the purulent drainage. The dressing saturated where we would be and the resiphysician board for a On 7/27/2016 at 1:40 was interviewed. She been scheduled on the assigned to wound can has not been assigned month. She explained | nent record indicated that a dressing of hydrocolloid ery 7 days and as needed, d for the application and no ents were indicated. As started on 7/9/2016 to essing daily and as needed to eright buttock. Treatment record indicated a 4 measuring 4 centimeter to sacrum with black eschar, saline and cover with a arting on 7/22/2016. The hydrocolloid was me. A referral for the wound duate was also noted at this re documented as a general form of a care and 7/26/2016 at 12:16 pm, by hidentified an unstageable neasurements of 6 cm x 5 ine depth. A description of ar with thick dark eschar ound bed, surrounding to the slightest touch, no the note indicated that a sith serous drainage was dent was placed on the | F                                      | physician order.  What measures were put in residents having the potential affected:  On 8/22/16 a 100% skin autompleted on all residents be nurse, DON, and/or QI nurse conditions and/or signs/symabuse/neglect, skin referrals treatment initiated, physician responsible party are notified documentation in the clinical include Wound Ulcer Flow SNon-Ulcer Flow sheets and Record as indicated. On 8 100% of all existing skin corrassessed by the MDS nurse for worsening with approprial interventions put in place, anotification. On 8/22/2016 flow sheets were completed staging, measurements, sig of infection, wound descripting notification and current treat 8/22/2016 100% of resident notes were reviewed for the by the MDS nurse, DON, an nurse for any acute change pressure ulcers have been in 8/22/2016 a 100% audit of a completed by the MDS nurse and/or QI nurse to ensure a conditions have treatments 8/22/2016 a wound meeting the Treatment nurse, DON, RD in attendance . Starting | dit was by the MDS e for new si ptoms of s created, n and d with I record to Sheet, Treatment 22/2016 nditions were e and/or DO ate nd MD/RP wound ulce to include ns/sympton on, RP/MD ment. On progress past 30 da ad/or the QI as to include dentified. O all TARs wa e, DON, II existing si in place. O was held v QI nurse, a | re DN er ns ys eDn ss kin on vith and |  |

| NAME OF PROVIDER OR SUPPLIER  PINE RIDGE HEALTH AND REHABILITATION CENTER    STREET ADDRESS, CITY, STATE, ZIP CODE 766 PINEYWOOD ROAD THOMASVILLE, NO. 27360   PREPRY CODE 766 PINEYWOOD ROAD THOMASVILLE, NO. 27360   PREPRY CALL PROVIDED BY CHARLES AND PREPRY CALL PROVIDED BY CHARLES AND PROVIDERS PLAN OF CORSECTION (EACH OEDERICATION MOST PREPRY TAG (EACH OEDERICATION MOST PREPRY TAG (EACH OEDERICATION MOST PREPRY TAG (EACH OEDERICATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPRICENCY) PROPERTY TAG (EACH OEDERICATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPRICENCY) PROVIDED BY CROSS-REFERENCED TO THE APPROPRIATE DEPRICENCY OF THE APPROPRIATE DEPRICED OF THE APPROPRIATE DEPRICENCY OF THE APPROPRIATE DEPRICED OF THE APPROPRIATE DEPR | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′       | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |      | (X3) DATE SURVEY<br>COMPLETED |  |
|--|---|----------------------|--|-----------|---|--|------|-------------------------------|--|
| PINE RIDGE HEALTH AND REHABILITATION CENTER  PINE RIDGE HEALTH AND REHABILITATION CENTER  PINE RIDGE HEALTH AND REHABILITATION CENTER  SIMMARY STATEMENT OF DEPOSITIONESS REPORT OF DEPOSITIONESS REACH DEPOSITION WIST LIKE PRECED BY FULL REGULATORY OR I.S.C. IDENTIFYING INFORMATION)  F 224  Continued From page 2 then. When asked who is responsible for wound care she explained that the nurses on the halls are supposed to do the weekly assessments, she indicated that the nurses on the hall are supposed to do the weekly assessments as well. First shift is responsible for the even number rooms and second shift does the odd number rooms and second shift does the odd number rooms.  On 7/27/2016 at 3:16 pm the MDS nurse was interviewed. She explained that the last documented assessment was on the treatment record, where a nurse had noted a busted bilister which would be a stage Il uluer. She verified that the reference to a bilister was the last assessment of the wound and that no formal skin assessments with measurements existed. She indicated that she went we can be explained that the nurse aide came to the rand told her that there was no freesing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foll udor. She explained that the rew so no freesing on Resident #2. The nurse indicated that the wound unservent back and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound nurse would do the dressings as scheduled on everings but no one has ever fold and that she wound do the dressings as scheduled on everings but no one has ever lotd.  STAGET TADMASYILLE, NC 27380  PREVENT ATAG (CONTINETON) CONTINETON CONTINETON CONTINETON CONTINETON CONTINETON.  PREVENT ATAG (CONTINETON) CONTINETON CONTINETON CONTINETON CONTINETON CONTINETON CONTINETON CONTINETON CONTINETON.  F 224  **STECT AND ASSEMBLE AND CONTINETON CONTINETON CONTINETON CONTINETON.  F 224  **STECT AND ASSEMBLE AND CONTINETON CONTINETON.  F 224  **STEC |   |                      |  |           |   |  |      | С                             |  |
| PINE RIDGE HEALTH AND REHABILITATION CENTER  TAG  FEREIX TAG  FOR MINIMARY STATEMENT OF DEFICIONES TAG  CANCELLA TAG  FOR MINIMARY STATEMENT OF DEFICIONES TAG  FOR MINIMARY STATEMENT OF DEFICIONES TAG  CANCELLA TAG  CANCELLA TAG  TAG  FOR MINIMARY STATEMENT OF DEFICIONES TAG  CANCELLA TAG  CANCELLA TAG  TAG  FOR MINIMARY STATEMENT OF DEFICIONES TAG  FOR MINIMARY STATEMENT OF DEFICIONES TAG  CANCELLA TAG  CANCELLA TAG  CANCELLA TAG  TAG  FOR MINIMARY STATEMENT OF DEFICIONES TAG  CANCELLA TAG  CANCELLA TAG  TAG  FOR MINIMARY STATEMENT OF DEFICIONES TAG  CANCELLA TAG  CANCELLA TAG  TAG  FOR MINIMARY STATEMENT OF DEFICIONES TAG  CANCELLA TAG  CANCELLA TAG  CANCELLA TAG  What systems were put in place to prevent the deficient practice from recocurring:  On 8/12/2016 at 300 in-service for all Staff including contract staff was initiated by the about a stage about the deficient practice from recocurring:  On 8/12/2016 at 300 in-service for all RN is and LPN is well and about the deficient practice from recocurring:  On 8/12/2016 at 300 in-service for all RN is and LPN is well and about the deficient practice from recocurring:  On 8/12/2016 at 300 in-service for all RN is and LPN is well and about the deficient practice from recocurring:  On 8/12/2016 at 300 in service for all RN is and LPN is well and about the service was initiated by the DON to all RN is an |   |                      | 345144   | B. WING _ |   |  | 07   | /28/2016                      |  |
| PINE RIDGE HEALTH AND REHABILITATION CENTER    (A)   ( | NAME OF P   | ROVIDER OR SUPPLIER  | _  |           | 5                                       | STREET ADDRESS, CITY, STATE, ZIP CODE  |      |                               |  |
| MAYOUNDERS   MAY   |   |                      |  |           | 7                                       | 706 PINEYWOOD ROAD   |      |                               |  |
| FREGULATORY OR LISC IDENTIFYING INFORMATION)  F224  Continued From page 2 then. When asked who is responsible for wound care she explained that the nurses on the halls are supposed to do their own resident 's wound care. When asked about the assessments, she indicated that the nurses on the hall are supposed to do their own resident 's wound care. When asked about the assessments, she indicated that the nurses on the hall are supposed to do the weekly assessments as well. First shift is responsible for the even number rooms and second shift does the odd number rooms.  On 7/27/2016 at 3:16 pm the MDS nurse was interviewed. She explained that she went in Resident #2 's room to do a wound assessment as part of the Change of Therapy assessment that she was doing. She explained that the last documented assessment which would be a stage if lucer. She verified that the reference to a blister was the last assessment of the wound and that no formal skin assessments with measurements existed. She indicated that she knew the wound care doctor would be here on Thursday and she wanted to make sure Resident #2 was seen.  On 7/27/2016 at 4:15 pm the nurse caring for Resident #2 was interviewed. She indicated that she knew the wound care doctor would be here on Thursday and she wanted to make sure Resident #2 was seen.  On 7/27/2016 at 4:15 pm the nurse caring for Resident #2 was used to the design of the wound was very black and necrotic with a foul odor. She explained that the nurse aide came to her and told her that there was no dressing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that the wound nurse would do the dressing can be a form of neglect and will be 100% to complete by 8/22/2016. On 8/19/2016 an in-service for all RN1 is and LPN1. Is was nitiated for all RN1 is and LPN1. Is was nitiated by the DON related to s/s of infection of a wound, so yet plack and the skin was just red, but has turned black. She that she does not do wound assessments and meas | PINE RIDO   | SE HEALTH AND REH    | ABILITATION CENTER   |           | 1                                       | THOMASVILLE, NC 27360  |      |                               |  |
| FREEDLY TAG REGULATORY OR LISC IDENTIFYING INFORMATION)  F224  Continued From page 2 then. When asked who is responsible for wound care she explained that the nurses on the halls are supposed to do their own resident 's wound care. When asked about the assessments, she indicated that the nurses on the hall are supposed to do their own meritage interviewed. She explained that she was often; She explained that she want in Resident #2's room to do a wound assessment as part of the Change of Therapy assessment that she was often; She explained that the last documented assessment which would be a stage if lucer. She verified that the reference to a blister was the last assessment of the wound and that no formal skin assessments with measurements existed. She indicated that she kew the wound care doctor would be here on Thursday and she wanted to make sure Resident #2 was seen. On 7/27/2016 at 4:15 pm the nurse caring for Resident #2. The nurse indicated that the hard the resident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that she wound unservery black and necrotic with a foul odor. She explained that she wound mass weny black and necrotic with a foul odor. She explained that she wound mass weny black and necrotic with a foul odor. She explained that the wound mass would do the dressing on Resident #2 was used to head on the control was usually as turned black. She that she does not do wound assessments and measurements. She explained that the wound mass would do the dressing on the properties of the pr | (X4) ID   | SUMMARY              | STATEMENT OF DEFICIENCIES  | ID        |   | PROVIDER'S PLAN OF CORRECTION  |      | (X5)                          |  |
| then. When asked who is responsible for wound care she explained that the nurses on the halls are supposed to do their own resident "s wound care. When asked about the assessments, she indicated that the nurses on the hall are supposed to do the weekly assessments as well. First shift is responsible for the even number rooms and second shift does the odd number rooms.  On 7/27/2016 at 3:16 pm the MDS nurse was interviewed. She explained that she want in Resident #2" is room to do a wound assessment that she was doing. She explained that the last documented assessment was on the treatment record, where a nurse had noted a busted blister which would be a stage II ulcer. She verified that the reference to a blister was the last assessment of the wound and that no formal skin assessments with measurements existed. She indicated that she knew the wound care doctor would be here on Thursday and she wanted to make sure Resident #2 was seen.  On 7/27/2016 at 4:15 pm the nurse caring for Resident #2 was seen. She explained that the nurse aide came to her and told her that there was no dressing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that the resident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound nurse would do that. She indicated that the wound nurse would do that. She indicated that the wound nurse would do that. She indicated that the wound nurse would do that. She indicated that the wound nurse would do that. She indicated that the wound nurse would do that she had the resident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound nurse would do that. She indicated that the wound nurse would do that. She indicated that the wound nurse would do that. She indicated that the wound nurse would be the dressings as schedule | PREFIX  | (EACH DEFICIE)       | NCY MUST BE PRECEDED BY FULL   | PREFI     |   | (EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA  |      | COMPLETION                    |  |
| care she explained that the nurses on the halls are supposed to do their own resident 's wound care. When asked about the assessments, she indicated that the nurses on the hall are supposed to do the weekly assessments as well. First shift is responsible for the even number rooms and second shift does the odd number rooms.  On 7/27/2016 at 3:16 pm the MDS nurse was interviewed. She explained that she went in Resident #2' is room to do a wound assessment as a part of the Change of Therapy assessment that she was doing. She explained that the last documented assessment was on the treatment record, where a nurse had noted a busted blister which would be a stage II ulcer. She verified that the reference to a blister was the last assessment of the wound and that no formal skin assessments with measurements existed. She indicated that she knew the wound care doctor would be here on Thursday and she wanted to make sure Resident #2 was seen.  On 7/27/2016 at 4:15 pm the nurse caring for Resident #2 was interviewed. She indicated that the nurse aide came to her and told her that there was no dressing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that she had the resident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound nurse would do that. She indicated that the wound nurse would do that. She indicated that the wound nurse would do that. She indicated that the wound on wound nurse would do the dressing on expert told.  daily as ordered.  What systems were put in place to prevent the deficient practice from reoccurring:  On 8/12/2016 a 100% in-service for all staff including signs and symptoms and will be completed by 8/22/2016. On 8/12/2016 an in-service to faill the poly signs and symptoms and will be completed by 8/22/2016. On 8/19/2016 an in-service to fail RNL's and LPNL's was defined to faill RNL's and LPNL's by the DON related to sign | F 224   | Continued From pa    | ge 2   | F 2       | 224                                     |  |      |                               |  |
| are supposed to do their own resident* s wound care. When asked about the assessments, she indicated that the nurses on the hail are supposed to do the weekly assessments as well. First shift is responsible for the even number rooms.  On 7/27/2016 at 3:16 pm the MDS nurse was interviewed. She explained that she went in Resident #2's room to do a wound assessment as part of the Change of Therapy assessment that she was doing. She explained that the last documented assessment was on the treatment record, where a nurse had noted a busted blister which would be a stage II ulcer. She verified that the reference to a blister was the last assessment at the reference to a blister was the last assessment of the wound and that no formal skin assessments with measurements existed. She indicated that she knew the wound care doctor would be here on Thursday and she wanted to make sure Resident #2 was interviewed. She indicated that she idd of the dressing change as expected last she did do the dressing change as expected last she did do the dressing change as expected last she did do the dressing change as expected last she did do the dressing change as expected last she and the resident when whe was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound nurse would do that. She indicated that the wound nurse would do that. She indicated that the wound research was scheduled on evenings but no one has ever told   |   | then. When asked     | who is responsible for wound   |           |   | assigned to complete resident treatme  | nts  |                               |  |
| care. When asked about the assessments, she indicated that the nurses on the hall are supposed to do the weekly assessments as well. First shift is responsible for the even number rooms and second shift does the odd number rooms.  On 7/27/2016 at 3:16 pm the MDS nurse was interviewed. She explained that she went in Resident #2's room to do a wound assessment as part of the Change of Therapy assessment that she was doing. She explained that the last documented assessment was on the treatment record, where a nurse had noted a busted blister which would be a stage II luder. She verified that the reference to a blister was the last assessment of the wound and that no formal skin assessments with measurements existed. She indicated that she knew the wound care doctor would be here on Thursday and she wanted to make sure Resident #2 was seen.  On 7/27/2016 at 4:15 pm the nurse caring for Resident #2 was seen. On 7/27/2016 at hindicated that the nurse aide came to her and told her that there was no dressing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that the had the resident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound nurse would do that. She indicated that she wound one has ever told  |   | care she explained   | that the nurses on the halls   |           |   | daily as ordered.  |      |                               |  |
| indicated that the nurses on the hall are supposed to do the weekly assessments as well. First shift is responsible for the even number rooms and second shift does the odd number rooms.  On 7/27/2016 at 3:16 pm the MDS nurse was interviewed. She explained that she went in Resident #2's room to do a wound assessment as part of the Change of Therapy assessment that she was doing. She explained that the last documented assessment was on the treatment record, where a nurse had noted a busted blister which would be a stage II ulcer. She verified that the reference to a blister was the last assessment of the wound and that no formal skin assessments with measurements existed. She indicated that she knew the wound care doctor would be here on Thursday and she wanted to make sure Resident #2 was seen.  On 7/27/2016 at 4:15 pm the nurse aide came to her and told her that there was no dressing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that the vesident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound undersease scheduled on evenings but no one has ever told   |   | are supposed to do   | their own resident 's wound  |           |   |  |      |                               |  |
| supposed to do the weekly assessments as well. First shift is responsible for the even number rooms and second shift does the odd number rooms.  On 7/27/2016 at 3:16 pm the MDS nurse was interviewed. She explained that she went in Resident #2's room to do a wound assessment as part of the Change of Therapy assessment that she was doing. She explained that the last documented assessment was on the treatment record, where a nurse had noted a busted blister which would be a stage II ulcer. She verified that the reference to a blister was the last assessment of the wound and that no formal skin assessments with measurements existed. She indicated that she knew the wound care doctor would be here on Thursday and she wanted to make sure Resident #2 was seen.  On 7/27/2016 at 4:15 pm the nurse caring for Resident #2 was interviewed. She indicated that she did do the dressing change as expected last night. She explained that the nurse aide came to her and told her that there was no dressing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that the head the resident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound nurse would do that. She indicated that she would do the dressings as scheduled on evenings but no one has ever told  |   | care. When asked     | about the assessments, she   |           |   | What systems were put in place to  |      |                               |  |
| First shift is responsible for the even number rooms and second shift does the odd number rooms.  On 7/27/2016 at 3:16 pm the MDS nurse was interviewed. She explained that she went in Resident #2' s room to do a wound assessment as part of the Change of Therapy assessment that she was doing. She explained that the last documented assessment was on the treatment record, where a nurse had noted a busted blister which would be a stage II ulcer. She verified that the reference to a blister was the last assessment of the wound and that no formal skin assessments with measurements existed. She indicated that she knew the wound care doctor would be here on Thursday and she wanted to make sure Resident #2 was seen.  On 7/27/2016 at 3:16 pm the MDS nurse was initiated by the Don the latted by the administrator related abuse/neglect including signs and symptons and will be completed by 8/22/2016 on 8/22/2016 on 8/22/2016 on 8/22/2016 on 8/22/2016. On 8/22/2016 o  |   | indicated that the n | urses on the hall are  |           |   | prevent the deficient practice from  |      |                               |  |
| rooms and second shift does the odd number rooms.  On 7/27/2016 at 3:16 pm the MDS nurse was interviewed. She explained that she went in Resident #2 's room to do a wound assessment as part of the Change of Therapy assessment that she was doing. She explained that the last documented assessment was on the treatment record, where a nurse had noted a busted blister which would be a stage II ulcer. She verified that the reference to a blister was the last assessment of the wound and that no formal skin assessments with measurements existed. She indicated that she knew the wound care doctor would be here on Thursday and she wanted to make sure Resident #2 was seen.  On 7/27/2016 at 4:15 pm the nurse caring for Resident #2 was interviewed. She indicated that she did do the dressing change as expected last night. She explained that the nurse aide came to her and told her that there was no dressing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that the wound nurse would do that. She indicated that she would do the dressings as scheduled on evenings but no one has ever told  On 8/12/2016 at 100% in-service for all staff including contract staff was initiated by the administrator related abuse/neglect including signs and symptoms and will be completed by %/22/2016 an in-service was initiated by the DON to all RN□s and LPN□s and delaying treatment for resident can be a form of neglect and will be 100% completed by 8/22/2016. On 8/19/2016 an in-service for all RN□s and LPN□s was initiated by the DON related to completing treatment as ordered, wound ulcer flowsheets and flowsheet of non-ulcer skin sheets, TARS, MD/RP notifications, and skin referrals will be 100% complete by 8/22/2016. On 8/19/2016 an in-service was initiated by the DON related to complete by 8/22/2016. On 8/19/2016 an in-service was initiated by the DON related to s/s of infection of a wound, to include to s/s of infection of a wound, to include 1) induration, 2) fever, 3) erythema, 4) edem  |   |                      |  |           |   | reoccurring:   |      |                               |  |
| staff including contract staff was initiated by the administrator related abuse/reglect including signs and symptoms and will be completed by 8/22/2016. On 8/22/2016 an in-service was interviewed. She explained that she went in Resident #2 's room to do a wound assessment that she was doing. She explained that the last documented assessment was on the treatment record, where a nurse had noted a busted blister which would be a stage II ulcer. She verified that the reference to a blister was the last assessment of the wound and that no formal skin assessments with measurements existed. She indicated that she knew the wound care doctor would be here on Thursday and she wanted to make sure Resident #2 was seen.  On 7/27/2016 at 4:15 pm the nurse caring for Resident #2 was interviewed. She indicated that she did to the dressing change as expected last night. She explained that the nurse aide came to her and told her that there was no dressing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that the wound nurse would do that. She indicated that she would do that she would do the dressings as scheduled on evenings but no one has ever told   |   |                      |  |           |   |  |      |                               |  |
| on 7/27/2016 at 3:16 pm the MDS nurse was interviewed. She explained that she went in Resident #2 's room to do a wound assessment as part of the Change of Therapy assessment that she was doing. She explained that the last documented assessment was on the treatment record, where a nurse had noted a busted blister which would be a stage II ulcer. She verified that the reference to a blister was the last assessment of the wound and that no formal skin assessments with measurements existed. She indicated that she knew the wound care doctor would be here on Thursday and she wanted to make sure Resident #2 was seen.  On 7/27/2016 at 4:15 pm the nurse caring for Resident #2 was interviewed. She indicated that she did do the dressing change as expected last night. She explained that the nurse aide came to her and told her that there was no dressing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that the wound assessments and measurements. She explained that the wound nurse would do that. She indicated that she would do the dressings as scheduled on evenings but no one has ever told  |   |                      | shift does the odd number  |           |   |  |      |                               |  |
| interviewed. She explained that she went in Resident #2 's room to do a wound assessment as part of the Change of Therapy assessment that she was doing. She explained that the last documented assessment was on the treatment record, where a nurse had noted a busted blister which would be a stage II ulcer. She verified that the reference to a blister was the last assessment of the wound and that no formal skin assessments with measurements existed. She indicated that she knew the wound care doctor would be here on Thursday and she wanted to make sure Resident #2 was seen.  On 7/27/2016 at 4:15 pm the nurse caring for Resident #2 was interviewed. She indicated that she did do the dressing change as expected last night. She explained that the nurse aide came to her and told her that there was no dressing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that the wound assessments and measurements. She explained that the wound dot that. She indicated that she had the resident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessment and measurements. She explained that the wound dot that. She indicated that she would do the dressings as scheduled on evenings but no one has ever told   |   |                      | 40 # 1400  |           |   |  | ∌d   |                               |  |
| Resident #2 's room to do a wound assessment as part of the Change of Therapy assessment that she was doing. She explained that the last documented assessment was on the treatment record, where a nurse had noted a busted blister which would be a stage II ulcer. She verified that the reference to a blister was the last assessment of the wound and that no formal skin assessments with measurements existed. She indicated that she knew the wound care doctor would be here on Thursday and she wanted to make sure Resident #2 was seen.  On 7/27/2016 at 4:15 pm the nurse caring for Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that the resident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound nurse would do the dressings as scheduled on evenings but no one has ever told  symptoms and will be completed by 8/22/2016 on In in-service was initiated by the DON to all RNIS and LPNIS and LP |   |                      | = -  |           |   | 1 -  |      |                               |  |
| as part of the Change of Therapy assessment that she was doing. She explained that the last documented assessment was on the treatment record, where a nurse had noted a busted blister which would be a stage II ulcer. She verified that the reference to a blister was the last assessment of the wound and that no formal skin assessments with measurements existed. She indicated that she knew the wound care doctor would be here on Thursday and she wanted to make sure Resident #2 was sinterviewed. She indicated that she did do the dressing change as expected last night. She explained that the nurse aide came to her and told her that there was no dressing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that the wound of the was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound one has ever told  8/22/2016. On 8/22/2016 on in-service was initiated by the DON to all RN□s and LPN□s the failure to report skin abnormalities to the physician and delaying treatment for resident can be a form of neglect and will be 100% completed by 8/22/2016. On 8/19/2016 an in-service for all RN□s and LPN□s will be 100% completed by 8/22/2016. On 8/19/2016 an in-service for all RN□s and LPN□s was initiated by the DON related to completing treatment for resident can be a form of neglect and will be 100% completed by 8/22/2016. On 8/19/2016 an in-service for all RN□s and LPN□s was initiated by the DON related to completing treatment for resident can be a form of neglect and will be 100% completed by 8/22/2016. On 8/19/2016 an in-service for all RN□s and LPN□s was initiated by the DON related to completing treatments as ordered, wound ulcer flowsheets and flowsheet of non-ulcer skin sheets, TARS, MD/RP notifications, and skin referrals will be 100% complete by 8/22/2016. On 8/19/2016 an in-service for all RN□s and LPN□s was initiated by the DON related to completing treatments as  |   |                      | •  |           |   |  |      |                               |  |
| that she was doing. She explained that the last documented assessment was on the treatment record, where a nurse had noted a busted blister which would be a stage II ulcer. She verified that the reference to a blister was the last assessment of the wound and that no formal skin assessments with measurements existed. She indicated that she knew the wound care doctor would be here on Thursday and she wanted to make sure Resident #2 was interviewed. She indicated that she knew the wound care doctor would be here on Thursday and she wanted to make sure Resident #2 was interviewed. She indicated that she did do the dressing change as expected last she did do the dressing change as expected last night. She explained that the nurse aidle came to her and told her that there was no dressing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that she had the resident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound nurse would do that. She indicated that she would do the dressings as scheduled on evenings but no one has ever told  |   |                      |  |           |   |  |      |                               |  |
| documented assessment was on the treatment record, where a nurse had noted a busted blister which would be a stage II ulcer. She verified that the reference to a blister was the last assessment of the wound and that no formal skin assessments with measurements existed. She indicated that she knew the wound care doctor would be here on Thursday and she wanted to make sure Resident #2 was seen.  On 7/27/2016 at 4:15 pm the nurse caring for Resident #2 was interviewed. She indicated that she did do the dressing change as expected last night. She explained that the nurse aide came to her and told her that there was no dressing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that she had the resident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound nurse would do that. She indicated that she would do the dressings as scheduled on evenings but no one has ever told  LPN□s related to failure to report skin abnormalities to the physician and delaying treatment for resident can be a form of neglect and will be 100% completed by 8/22/2016. On 8/19/2016 an in-service for all RN□s and LPN□s was initiated by the DON related to completing treatments as ordered, wound ulcer flowsheets and flowsheet of non-ulcer skin sheets, TARS, MD/RP notifications, and skin referrals will be 100% complete by 8/22/2016. On 8/19/2016 an in-service for all RN□s and LPN□s was initiated by the DON related to completing treatments as ordered, wound ulcer flowsheets and flowsheet of non-ulcer skin sheets, TARS, MD/RP notifications, and skin referrals will be 100% complete by 8/22/2016. On 8/19/2016 an in-service for all RN□s and LPN□s by 42/2016. On 8/19/2016 an in-service for all RN□s and LPN□s by 42/2016. On 8/19/2016 an in-service for all RN□s and LPN□s by 42/2016. On 8/19/2016 an in-service for all RN□s and LPN□s by 42/2016. On 8/19/2016 an in-service for all RN□s a  |   |                      |  |           |   |  |      |                               |  |
| record, where a nurse had noted a busted blister which would be a stage II ulcer. She verified that the reference to a blister was the last assessment of the wound and that no formal skin assessments with measurements existed. She indicated that she knew the wound care doctor would be here on Thursday and she wanted to make sure Resident #2 was seen.  On 7/27/2016 at 4:15 pm the nurse caring for Resident #2 was interviewed. She indicated that she did do the dressing change as expected last night. She explained that the nurse aide came to her and told her that there was no dressing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that she had the resident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound nurse would do that. She indicated that she would oot the dressings as scheduled on evenings but no one has ever told  abnormalities to the physician and delaying treatment for resident can be a form of neglect and will be 100% completed by 8/22/2016. On 8/19/2016 an in-service for all RN□s and LPN□s was initiated by the DON related to completing treatments as ordered, wound ulcer flowsheets and flowsheet of non-lucer skin sheets, TARS, MD/RP notifications, and skin referrals will be 100% complete by 8/22/2016. On 8/19/2016 an in-service for all RN□s and LPN□s wound ulcer flowsheets and flowsheet of non-lucer skin sheets, TARS, MD/RP notifications, and skin referrals will be 100% complete by 8/22/2016. On 8/19/2016 an in-service for all RN□s and LPN□s wound ulcer flowsheets and flowsheet of non-lucer skin sheets, TARS, MD/RP notifications, and skin referrals will be 100% complete by 8/22/2016. On 8/19/2016 an in-service for all RN□s and LPN□s wound ulcer flowsheets and flowsheet of non-lucer skin sheets, TARS, MD/RP notifications, and skin referrals will be 100% so finitiated by the DON related to so so finitiated for all RN□s and LPN□  |   | _                    | The state of the s |           |   | -  | IIIu |                               |  |
| which would be a stage II ulcer. She verified that the reference to a blister was the last assessment of the wound and that no formal skin assessments with measurements existed. She indicated that she knew the wound care doctor would be here on Thursday and she wanted to make sure Resident #2 was seen.  On 7/27/2016 at 4:15 pm the nurse caring for Resident #2 was interviewed. She indicated that she did do the dressing change as expected last she did do the dressing change as expected last one rand told her that there was no dressing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that she had the resident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that she would do the dressings as scheduled on evenings but no one has ever told  |   |                      |  |           |   | 1  |      |                               |  |
| the reference to a blister was the last assessment of the wound and that no formal skin assessments with measurements existed. She indicated that she knew the wound care doctor would be here on Thursday and she wanted to make sure Resident #2 was seen.  On 7/27/2016 at 4:15 pm the nurse caring for Resident #2 was interviewed. She indicated that she did do the dressing change as expected last night. She explained that the rurse aide came to her and told her that there was no dressing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that she had the resident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound nurse would do that. She indicated that she would on evenings but no one has ever told  form of neglect and will be 100% completed by 8/22/2016. On 8/19/2016 an in-service for all RN is and LPN is and in-service for all RN is and LPN is and LPN is an in-service for all RN is and LPN is and LPN is an in-service for all RN is and LPN is and in-service for all RN is and LPN is and LPN is an in-service for all RN is and LPN is and LPN is an in-service for all RN is and LPN is and in-service for all RN is and LPN is and in-service for all RN is and LPN is and in-service for all RN is and LPN is and LPN is an in-service for all RN is and LPN is and in-service for all RN is and LPN is and in-service for all RN is and LPN is and in-service for all RN is and LPN is and in-service for all RN is and LPN is and in-service for all RN is and LPN is and in-service for all RN is and LPN is and in-service for all RN is and LPN is and in-service for all RN is and LPN is and in-service for all RN is and LPN is and in-service for all RN is and LPN is and in-service for all RN is and LPN is and in-service for all RN is and LPN is and in-service for all RN is and LPN is and in-service for all RN is and LPN is and |   |                      |  |           |   | 1  | а    |                               |  |
| of the wound and that no formal skin assessments with measurements existed. She indicated that she knew the wound care doctor would be here on Thursday and she wanted to make sure Resident #2 was seen.  On 7/27/2016 at 4:15 pm the nurse caring for Resident #2 was interviewed. She indicated that she did do the dressing change as expected last night. She explained that the nurse aide came to her and told her that there was no dressing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that she had the resident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound do that. She indicated that she would do the dressings as scheduled on evenings but no one has ever told  completed by 8/22/2016. On 8/19/2016 an in-service for all RN□s and LPN□s was initiated to completing treatments as ordered, wound ulcer flowsheets and flowsheet of non-ulcer skin sheets, TARS, MD/RP notifications, and skin referrals will be 100% complete by 8/22/2016. On 8/19/2016 an in-service for all RN□s and LPN□s by the DON related to completing treatments as ordered, wound ulcer flowsheets and flowsheet of non-ulcer skin sheets, TARS, MD/RP notifications, and skin referrals will be 100% complete by 8/22/2016. On 8/19/2016 an in-service for all RN□s and LPN□s has intitated by the DON related to completing treatments as ordered, wound ulcer flowsheets and flowsheet of non-ulcer skin sheets, TARS, MD/RP notifications, and skin referrals will be 100% complete by 8/22/2016. On sinitiated by the DON related to solon from the form of the provide that the DON related to solon from all RN□s and LPN□s by the DON related to solon from all RN□s and LPN□s by the DON related to solon from all RN□s and LPN□s by the DON related to solon from all RN□s and LPN□s by the DON related to solon from all RN□s and LPN□s by the DON related to solon from all RN□s and LPN□s by the DON related to solon  |   |                      | _  |           |   | 1 -  | -    |                               |  |
| assessments with measurements existed. She indicated that she knew the wound care doctor would be here on Thursday and she wanted to make sure Resident #2 was seen.  On 7/27/2016 at 4:15 pm the nurse caring for Resident #2 was interviewed. She indicated that she did do the dressing change as expected last night. She explained that there was no dressing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that she had the resident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound nurse would do the dressings as scheduled on evenings but no one has ever told  an in-service for all RN□s and LPN□s was initiated by the DON related to completing treatments as ordered, wound ulcer flowsheets and flowsheet of non-ulcer skin sheets, TARS, MD/RP notifications, and skin referrals will be 100% complete by 8/22/2016. On 8/19/2016 an in-service was initiated by the DON related to completing treatments as ordered, wound ulcer flowsheets and flowsheet of non-ulcer skin sheets, TARS, MD/RP notifications, and skin referrals will be 100% complete by 8/22/2016. On all RN□s and LPN□s by the DON related to s/s of infection of a wound, to include to s/s of infection of a wound, to include 1) induration, 2) fever, 3) erythema, 4) edema, 5) increased WBC count, 7) foul smelling, purulent wound drainage, 8) decreased appetite, 9) general malaise, 10) failure to heal or sudden worsening of wound, staging of wounds, interventions, and MD/RP notification, will be 100% by  |   |                      |  |           |   |  | 6    |                               |  |
| would be here on Thursday and she wanted to make sure Resident #2 was seen. On 7/27/2016 at 4:15 pm the nurse caring for Resident #2 was interviewed. She indicated that she did do the dressing change as expected last night. She explained that the nurse aide came to her and told her that there was no dressing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that she had the resident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound nurse would do that. She indicated that she would do the dressings as scheduled on evenings but no one has ever told  completing treatments as ordered, wound ulcer flowsheets and flowsheet of non-ulcer skin sheets, TARS, MD/RP notifications, and skin referrals will be 100% complete by 8/22/2016. On 8/19/2016 an in-service was initiated for all RN□s and LPN□s by the DON related to s/s of infection of a wound, to include 1) induration, 2) fever, 3) erythema, 4) edema, 5) increased pain at the wound site, 6) increased WBC count, 7) foul smelling, purulent wound drainage, 8) decreased appetite, 9) general malaise, 10) failure to heal or sudden worsening of wound, staging of wounds, interventions, and MD/RP notifications, and flowsheet of non-ulcer skin sheets, TARS, MD/RP notifications, and skin referrals will be 100% complete by 8/22/2016. On 8/19/2016 an in-service was initiated for all RN□s and LPN□s by the DON related to s/s of infection of a wound, to include site, 6) increased pain at the wound site, 6) increased WBC count, 7) foul smelling, purulent wound drainage, 8) decreased appetite, 9) general malaise, 10) failure to heal or sudden worsening of wound, staging of wounds, interventions, and MD/RP notification, will be 100% by  |   | assessments with r   | neasurements existed. She  |           |   | 1  |      |                               |  |
| make sure Resident #2 was seen.  On 7/27/2016 at 4:15 pm the nurse caring for Resident #2 was interviewed. She indicated that she did do the dressing change as expected last night. She explained that the nurse aide came to her and told her that there was no dressing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that she had the resident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound nurse would do that. She indicated that she would do the dressings as scheduled on evenings but no one has ever told  ulcer flowsheets and flowsheet of non-ulcer skin sheets, TARS, MD/RP notifications, and skin referrals will be 100% complete by 8/22/2016. On 8/19/2016 an in-service was initiated for all RN□s and LPN□s by the DON related to s/s of infection of a wound, to include 1) induration, 2) fever, 3) erythema, 4) edema, 5) increased pain at the wound site, 6) increased WBC count, 7) foul smelling, purulent wound drainage, 8) decreased appetite, 9) general malaise, 10) failure to heal or sudden worsening of wound, staging of wounds, interventions, and MD/RP notifications, and skin referrals will be 100% complete by 8/22/2016. On 8/19/2016 an in-service was initiated for all RN□s and LPN□s by the DON related to s/s of infection of a wound, to include 1) induration, 2) fever, 3) erythema, 4) edema, 5) increased WBC count, 7) foul smelling, purulent wound drainage, 8) decreased appetite, 9) general malaise, 10) failure to heal or sudden worsening of wound, staging of wounds, interventions, and MD/RP notifications, and skin referrals will be 100% by 100% to   |   | indicated that she k | new the wound care doctor  |           |   | was initiated by the DON related to  |      |                               |  |
| On 7/27/2016 at 4:15 pm the nurse caring for Resident #2 was interviewed. She indicated that she did do the dressing change as expected last night. She explained that the nurse aide came to her and told her that there was no dressing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that she had the resident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound nurse would do that. She indicated that she would do the dressings as scheduled on evenings but no one has ever told  non-ulcer skin sheets, TARS, MD/RP notifications, and skin referrals will be 100% complete by 8/22/2016. On 8/19/2016 an in-service was initiated for all RN she and LPN she by the DON related to s/s of infection of a wound, to include 1) induration, 2) fever, 3) erythema, 4) edema, 5) increased pain at the wound site, 6) increased WBC count, 7) foul smelling, purulent wound drainage, 8) decreased appetite, 9) general malaise, 10) failure to heal or sudden worsening of wound, staging of wounds, interventions, and MD/RP notifications, and skin referrals will be 100% complete by 8/22/2016. On 8/19/2016 an in-service was initiated for all RN she the DON related to s/s of infection of a wound, to include 1) induration, 2) fever, 3) erythema, 4) edema, 5) increased WBC count, 7) foul smelling, purulent wound drainage, 8) decreased appetite, 9) general malaise, 10) failure to heal or sudden worsening of wound, staging of wounds, interventions, and MD/RP notification, will be 100% by   |   | would be here on T   | hursday and she wanted to  |           |   | completing treatments as ordered, wou  | und  |                               |  |
| Resident #2 was interviewed. She indicated that she did do the dressing change as expected last night. She explained that the nurse aide came to her and told her that there was no dressing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that she had the resident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound nurse would do that. She indicated that she would do the dressings as scheduled on evenings but no one has ever told  notifications, and skin referrals will be 100% complete by 8/22/2016. On 8/19/2016 an in-service was initiated for all RN service was intiated for all RN service was interested to seven, 5) increased p |   | make sure Residen    | it #2 was seen.  |           |   | ulcer flowsheets and flowsheet of  |      |                               |  |
| she did do the dressing change as expected last night. She explained that the nurse aide came to her and told her that there was no dressing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that she had the resident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound nurse would do that. She indicated that she would do the dressings as scheduled on evenings but no one has ever told  100% complete by 8/22/2016. On 8/19/2016 an in-service was initiated for all RN□s and LPN□s by the DON related to s/s of infection of a wound, to include 1) induration, 2) fever, 3) erythema, 4) edema, 5) increased pain at the wound site, 6) increased WBC count, 7) foul smelling, purulent wound drainage, 8) decreased appetite, 9) general malaise, 10) failure to heal or sudden worsening of wound, staging of wounds, interventions, and MD/RP notification, will be 100% by  |   | On 7/27/2016 at 4:   | 15 pm the nurse caring for   |           |   | non-ulcer skin sheets, TARS, MD/RP   |      |                               |  |
| night. She explained that the nurse aide came to her and told her that there was no dressing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that she had the resident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound nurse would do that. She indicated that she would do the dressings as scheduled on evenings but no one has ever told  8/19/2016 an in-service was initiated for all RN□s and LPN□s by the DON related to s/s of infection of a wound, to include 1) induration, 2) fever, 3) erythema, 4) edema, 5) increased pain at the wound site, 6) increased WBC count, 7) foul smelling, purulent wound drainage, 8) decreased appetite, 9) general malaise, 10) failure to heal or sudden worsening of wound, staging of wounds, interventions, and MD/RP notification, will be 100% by   |   | Resident #2 was in   | terviewed. She indicated that  |           |   |  |      |                               |  |
| her and told her that there was no dressing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that she had the resident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound nurse would do that. She indicated that she would do the dressings as scheduled on evenings but no one has ever told  all RN□s and LPN□s by the DON related to s/s of infection of a wound, to include to s/s of infection of a wound, stage the policy in the policy infection of a wound, stage the policy infection of a wound, to include to s/s of infection of a wound, to include to s/s of infection of a wound, to include to s/s of infection of a wound, to include to s/s of infection of a wound, to include to s/s of infection of a wound to s/s of infecti |   |                      |  |           |   | 100% complete by 8/22/2016. On   |      |                               |  |
| Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that she had the resident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound nurse would do that. She indicated that she would do the dressings as scheduled on evenings but no one has ever told to s/s of infection of a wound, to include 1) induration, 2) fever, 3) erythema, 4) edema, 5) increased pain at the wound site, 6) increased WBC count, 7) foul smelling, purulent wound drainage, 8) decreased appetite, 9) general malaise, 10) failure to heal or sudden worsening of wound, staging of wounds, interventions, and MD/RP notification, will be 100% by  |   |                      |  |           |   |  |      |                               |  |
| was very black and necrotic with a foul odor. She explained that she had the resident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound nurse would do that. She indicated that she would do the dressings as scheduled on evenings but no one has ever told  1) induration, 2) fever, 3) erythema, 4) edema, 5) increased pain at the wound site, 6) increased WBC count, 7) foul smelling, purulent wound drainage, 8) decreased appetite, 9) general malaise, 10) failure to heal or sudden worsening of wound, staging of wounds, interventions, and MD/RP notification, will be 100% by  |   |                      | •  |           |   |  |      |                               |  |
| explained that she had the resident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound nurse would do that. She indicated that she would do the dressings as scheduled on evenings but no one has ever told  edema, 5) increased pain at the wound site, 6) increased WBC count, 7) foul smelling, purulent wound drainage, 8) decreased appetite, 9) general malaise, 10) failure to heal or sudden worsening of wound, staging of wounds, interventions, and MD/RP notification, will be 100% by   |   |                      |  |           |   | The state of the s |      |                               |  |
| was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound nurse would do that. She indicated that she would do the dressings as scheduled on evenings but no one has ever told  site, 6) increased WBC count, 7) foul smelling, purulent wound drainage, 8) decreased appetite, 9) general malaise, 10) failure to heal or sudden worsening of wound, staging of wounds, interventions, and MD/RP notification, will be 100% by  |   | · -                  |  |           |   | 1 1  |      |                               |  |
| has turned black. She that she does not do wound assessments and measurements. She explained that the wound nurse would do that. She indicated that she would do the dressings as scheduled on evenings but no one has ever told  smelling, purulent wound drainage, 8) decreased appetite, 9) general malaise, 10) failure to heal or sudden worsening of wound, staging of wounds, interventions, and MD/RP notification, will be 100% by  |   |                      |  |           |   |  | 1    |                               |  |
| wound assessments and measurements. She explained that the wound nurse would do that. She indicated that she would do the dressings as scheduled on evenings but no one has ever told  decreased appetite, 9) general malaise, 10) failure to heal or sudden worsening of wound, staging of wounds, interventions, and MD/RP notification, will be 100% by   |   |                      | •  |           |   |  |      |                               |  |
| explained that the wound nurse would do that.  She indicated that she would do the dressings as scheduled on evenings but no one has ever told  10) failure to heal or sudden worsening of wounds, interventions, and MD/RP notification, will be 100% by  |   |                      |  |           |   |  | _    |                               |  |
| She indicated that she would do the dressings as scheduled on evenings but no one has ever told wound, staging of wounds, interventions, and MD/RP notification, will be 100% by   |   |                      |  |           |   |  |      |                               |  |
| scheduled on evenings but no one has ever told and MD/RP notification, will be 100% by   |   |                      |  |           |   | 1 '  | •    |                               |  |
|  |   |                      |  |           |   |  |      |                               |  |
|  |   |                      |  |           |   |  |      |                               |  |
| On 7/27/2016 at 4:29 pm the nurse supervisor for all CNA s and medication aides by the   |   |                      |  |           |   |  |      |                               |  |

|               | OF DEFICIENCIES<br>CORRECTION | IDENTIFICATION NUMBER                                       |              | 2) MULTIPLE CONSTRUCTION BUILDING |  |       | (X3) DATE SURVEY<br>COMPLETED |  |
|---------------|-------------------------------|---|--------------|-----------------------------------|--|-------|-------------------------------|--|
|               |                               |   | A. BOILD     | NG _                              |  | (     | •                             |  |
|               |                               | 345144  | B. WING      |                                   |  | 1     | 28/2016                       |  |
| NAME OF P     | ROVIDER OR SUPPLIER           | •   |              | S                                 | TREET ADDRESS, CITY, STATE, ZIP CODE   | -     |                               |  |
| DINE DID      | NE LIEALTH AND DELLA          | DILITATION OFNITED  |              | 70                                | 06 PINEYWOOD ROAD  |       |                               |  |
| PINE RIDO     | SE HEALTH AND REHA            | BILITATION CENTER   |              | Т                                 | HOMASVILLE, NC 27360   |       |                               |  |
| (X4) ID       | SUMMARY S                     | TATEMENT OF DEFICIENCIES                                    | ID           |                                   | PROVIDER'S PLAN OF CORRECTION  |       | (X5)                          |  |
| PRÉFIX<br>TAG | ,                             | CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREFI<br>TAG |                                   | (EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |       | COMPLETION<br>DATE            |  |
| F 224         | Continued From pag            | e 3   | F            | 224                               |  |       |                               |  |
|               |                               | ewed. She explained that                                    | '            |                                   | DON related to notification to nurse of  |       |                               |  |
|               |                               | sible for the odd number                                    |              |                                   | new skin condition observed and  |       |                               |  |
|               |                               | ges. When asked about                                       |              |                                   | dressings being off or saturated and wi  | 11    |                               |  |
|               |                               | and measurements, she                                       |              |                                   | be 100% complete by 8/22/2016. On  | "     |                               |  |
|               |                               | ound nurse would do those                                   |              |                                   | 8/22/2016 the treatment was in-service   | :d    |                               |  |
|               |                               | on the hall would not be                                    |              |                                   | by the DON related to completing   |       |                               |  |
|               | responsible for woun          |   |              |                                   | treatments as ordered, TARS, skin  |       |                               |  |
|               | On 7/28/2016 at 10:0          | 09 am wound assessment                                      |              |                                   | referrals, completion of wound ulcer   |       |                               |  |
|               |                               | red with the consulting wound                               |              |                                   | flowsheets and flowsheet of non-ulcer  |       |                               |  |
|               |                               | ne wound care nurse. The                                    |              |                                   | skin sheets (how to complete and must  |       |                               |  |
|               |                               | in an upright position in bed                               |              |                                   | completed every 7 days), notification o  |       |                               |  |
|               |                               | d. The physician instructed                                 |              |                                   | MD and RP of new areas and worsenir  | ıg    |                               |  |
|               |                               | e to make sure she was                                      |              |                                   | of areas. On 8/16/2016 the director of   |       |                               |  |
|               | _                             | han 30 degrees due to the                                   |              |                                   | nursing, nursing supervisors, and all  |       |                               |  |
|               |                               | n would put on her back. He<br>an air mattress to relieve   |              |                                   | on-call nurses were in-serviced by the administrator that a staff member or          |       |                               |  |
|               |                               | e while in bed. The resident                                |              |                                   | members must be assigned to complet  | - Δ   |                               |  |
|               | was lowered and turi          |   |              |                                   | treatments daily as ordered. No staff w  |       |                               |  |
|               |                               | ed. A strong foul odor was                                  |              |                                   | be allowed to work after 8/22/2016 unti  |       |                               |  |
|               | _                             | n explained that the smell                                  |              |                                   | in-services are completed. All new hire  |       |                               |  |
|               |                               | sue. He tapped the eschar                                   |              |                                   | will receive in-services during new  |       |                               |  |
|               | and noted that it was         |   |              |                                   | employee orientation.  |       |                               |  |
|               | explained that it need        | ded debriding.  |              |                                   |  |       |                               |  |
|               | Measurements were             | completed by the physician                                  |              |                                   | How the facility will monitor systems pu   | ıt in |                               |  |
|               |                               | n x 5 cm x 1 cm, estimated                                  |              |                                   | place:   |       |                               |  |
|               |                               | The physician explained                                     |              |                                   |  |       |                               |  |
|               | that it would probably        |   |              |                                   | On 8/19/2016 the MDS nurse, QI nurse   |       |                               |  |
|               |                               | dement was attempted by the                                 |              |                                   | and/or the DON began auditing 100%   | of    |                               |  |
|               |                               | e amount of black substance                                 |              |                                   | resident progress notes for any acute  | ,     |                               |  |
|               |                               | ound bed. The physician                                     |              |                                   | changes to include new or worsening o  |       |                               |  |
|               |                               | s not able to get it all today                              |              |                                   | skin conditions using the 24 hour repor sheets. On 8/19/2016 the MDS nurse,          | ι     |                               |  |
|               | rest.                         | ack next Thursday to do the                                 |              |                                   | DON, and/or QI nurse began auditing  |       |                               |  |
|               |                               | 12 am the wound care nurse                                  |              |                                   | 100% of the TARS, wound ulcer flow   |       |                               |  |
|               |                               | ng the dressing to Resident                                 |              |                                   | sheets, flow sheets of non-ulcer   |       |                               |  |
|               |                               | She noted that urine was                                    |              |                                   | conditions and skin referrals for  |       |                               |  |
|               |                               | ident was moved. She  |              |                                   | completion and accuracy using the 24   |       |                               |  |
|               | _                             | nay benefit from a urinary                                  |              |                                   | hour report sheets. A The Treatment  |       |                               |  |
|               | catheter. She applie          |   |              |                                   | nurse, or RN nurses will conduct a skir  | ı     |                               |  |

| OLIVILIV      | O T OIT MEDIO, TILE &         | WEDIO/ ND CEITVICEC  |              |     |  | <u> </u>          | 7. 0000 000 1      |
|---------------|-------------------------------|--|--------------|-----|--|-------------------|--------------------|
|               | DF DEFICIENCIES<br>CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         | ` ′          |     | CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED    |
|               |                               |  |              | _   |  | (                 | 0                  |
|               |                               | 345144   | B. WING      |     |  |                   | 28/2016            |
| NAME OF PI    | ROVIDER OR SUPPLIER           | 1  |              | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |                   | 20/2010            |
|               |                               |  |              | 70  | 06 PINEYWOOD ROAD  |                   |                    |
| PINE RIDO     | SE HEALTH AND REHAE           | BILITATION CENTER  |              | Т   | HOMASVILLE, NC 27360   |                   |                    |
| (X4) ID       | SUMMARY ST                    | ATEMENT OF DEFICIENCIES                                    | ID           |     | PROVIDER'S PLAN OF CORRECTION  |                   | (X5)               |
| PREFIX<br>TAG | ,                             | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREFI<br>TAG |     | (EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                   | COMPLETION<br>DATE |
| F 224         | Continued From page           | e 4  | F            | 224 |  |                   |                    |
|               | · -                           | the wound bed with calcium                                 |              |     | audit of 10% of the residents and  |                   |                    |
|               | alginate over that and        |  |              |     | observations for any acute change in   |                   |                    |
|               | dressing.                     | ,  |              |     | condition 2x a week x 4 weeks, then  |                   |                    |
|               |                               | , on 7/28/2016 at 11:33 am                                 |              |     | weekly x 4 weeks, then monthly x 1 mo  | onth              |                    |
|               |                               | e was interviewed. She                                     |              |     | using the Chart Audit Tool to ensure a   |                   |                    |
|               | indicated that she do         | es not see the wounds like                                 |              |     | new or worsening skin abnormalities to   | 1                 |                    |
|               |                               | explained that she has not                                 |              |     | include pressure ulcers have been  |                   |                    |
|               |                               | the wound care nurse                                       |              |     | identified, skin referrals created, treatm   |                   |                    |
|               | because they do not           |  |              |     | initiated, physician and responsible par   | ty                |                    |
|               |                               | , "They schedule me to                                     |              |     | are notified with documentation in the   |                   |                    |
|               |                               | 't do two things at once. "                                |              |     | clinical record to include Wound Ulcer   |                   |                    |
|               |                               | e nurses rely on the direct                                |              |     | Flow Sheet, Non-Ulcer Flow sheets an   | a                 |                    |
|               | care staff to report ch       | urses try to do a good job                                 |              |     | Treatment Record as indicated. Any concerns will be addressed immediated             | V                 |                    |
|               |                               | ey are assigned 40 plus                                    |              |     | by the treatment nurse or RN nurse with  | •                 |                    |
|               | _                             | /hen asked if the lack of                                  |              |     | an assessment of the skin abnormality  |                   |                    |
|               |                               | had impacted the wound for                                 |              |     | initiation of treatment, creation of a Ski   |                   |                    |
|               |                               | cated that it had, explaining                              |              |     | Referral, notification of the physician a  |                   |                    |
|               | · ·                           | entions that were identified                               |              |     | responsible party, and documentation   |                   |                    |
|               | today could have bee          | en implemented earlier. She                                |              |     | findings in the clinical record to include   |                   |                    |
|               | indicated that when F         | Resident #2 came to the                                    |              |     | Wound Ulcer Flow Sheet, Non-Ulcer F  | ow                |                    |
|               | facility her wound wa         | s small. As a wound care                                   |              |     | Sheet, and Treatment Record. All aud   | its               |                    |
|               |                               | that she had been trained to                               |              |     | will be completed 2x a week x 4 weeks  |                   |                    |
|               | assess wounds for ch          | -  |              |     | then weekly x 4 weeks, then monthly x  | 1                 |                    |
|               |                               | xplained that her priority                                 |              |     | month.   |                   |                    |
|               |                               | change treatments per                                      |              |     | 0.5 0/00/0040 5  | -1-1              |                    |
|               |                               | nd care referrals, change                                  |              |     | On 8/22/2016 a wound meeting was h   | eia               |                    |
|               |                               | possible ask for a catheter to                             |              |     | with the Treatment nurse, DON, QI  |                   |                    |
|               |                               | oaking the wound. She have been aware of these             |              |     | nurse, and dietary manager in attendar using the wound QI tool . The meeting         |                   |                    |
|               |                               | nmunicated them to the                                     |              |     | continue to be held weekly x 12 weeks  |                   |                    |
|               | physician to put them         |  |              |     | then monthly.  |                   |                    |
|               | Staffing for June and         |  |              |     |  |                   |                    |
|               |                               | e wound care nurse was not                                 |              |     |  |                   |                    |
|               |                               | eatments about half of the                                 |              |     |  |                   |                    |
|               | _                             | ind care nurse was assigned                                |              |     |  |                   |                    |
|               | to wound care only 4          |  |              |     |  |                   |                    |
|               | -                             | pm the Director of Nursing                                 |              |     |  |                   |                    |
|               |                               | e explained that for the last                              |              |     |  |                   |                    |

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | , ,                 | PLE CONSTRUCTION  G  | COMP   | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|---|---------------------|--|--|-------------------------------|--|
|                          |   | 345144  | B. WING _           |  |  | C<br>28/2016                  |  |
|                          | ROVIDER OR SUPPLIER  BE HEALTH AND REHAE  | BILITATION CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>706 PINEYWOOD ROAD<br>THOMASVILLE, NC 27360   |  | 20/2010                       |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY)   | HOULD BE   | (X5)<br>COMPLETION<br>DATE    |  |
| F 224 F 282 SS=G         | assigned to wound covacation and for two take a hall. She expl She staffed the floor so the halls would be floor nurses to do the indicated that would it 483.20(k)(3)(ii) SERN PERSONS/PER CAFT The services provide must be provided by accordance with each care.  This REQUIREMENT by:  Based on record revinterviews and physic failed to follow the canot providing wound | and care nurse was not are. One week she was on weeks she was assigned to ained that it was necessary. With the wound care nurse covered and expected the ir own wound care. She include assessing wounds. VICES BY QUALIFIED RE PLAN do or arranged by the facility qualified persons in a resident's written plan of is not met as evidenced iew, observations, staff cian interview, the facility re plan and skin protocol by | F 2                 |  | out in place   | 8/22/16                       |  |
|                          | progressed to an unseschar, for 1 of 3 resireviewed for pressure The findings included The undated skin car included that the skin appropriate personne changes. The protoccould be done by Nurpersonnel during dail nurses.  The skin care protocc be thoroughly assess  | tageable pressure ulcer with dents (Resident #2) e ulcers.  |                     | On 8/9/2016 resident #2□s care reviewed by the MDS Nurse to skin impairment to the sacrum vincluded in the focus.  What measures were put in place residents having the potential to affected:  On 8/22/16 the MDS Nurses co 100% audit of resident□s with pulcers care plans to ensure accoincluding staging and intervention care plans were updated as necession. | ensure was  ce for be empleted a pressure uracy ons. All |                               |  |

PRINTED: 09/01/2016 FORM APPROVED OMB NO. 0938-0391

|               | OF DEFICIENCIES<br>CORRECTION | IDENTIFICATION NUMBER:   |              |      | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                    |
|---------------|-------------------------------|--|--------------|------|--|-------------------------------|--------------------|
|               |                               |  | A. BUILDI    | NG _ |  | Ι,                            | _                  |
|               |                               | 345144   | B. WING      |      |  |                               | 28/2016            |
| NAME OF P     | ROVIDER OR SUPPLIER           |  |              | S    | TREET ADDRESS, CITY, STATE, ZIP CODE   | , , , ,                       |                    |
|               |                               |  |              | 70   | 06 PINEYWOOD ROAD  |                               |                    |
| PINE RIDO     | SE HEALTH AND REHA            | ABILITATION CENTER   |              | Т    | HOMASVILLE, NC 27360   |                               |                    |
| (X4) ID       | SUMMARY                       | STATEMENT OF DEFICIENCIES                                      | ID           |      | PROVIDER'S PLAN OF CORRECTION  |                               | (X5)               |
| PREFIX<br>TAG | (EACH DEFICIEN                | NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION) | PREFI<br>TAG |      | (EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   |                               | COMPLETION<br>DATE |
| F 282         | Continued From pa             | ge 6   | F            | 282  |  |                               |                    |
|               | -                             | =  |              | 202  | On 8/22/16 a 100% audit of residents v   | with                          |                    |
|               | included by wound             | staging.<br>Il thickness skin loss) - If                       |              |      | skin impairments care plan were audite   | -                             |                    |
|               |                               | moderate amount of drainage                                    |              |      | to ensure interventions were being   | ;u                            |                    |
|               |                               | d and change every seven                                       |              |      | followed, to include the wound care  |                               |                    |
|               | days and as needed            | •  |              |      | protocol and weekly assessments were   | ا د                           |                    |
|               |                               | nickness tissue loss) and Stage                                |              |      | completed by 8/22/16.  | <i>'</i>                      |                    |
|               |                               | sue loss with exposed bone,                                    |              |      | Sompleted by 6/22/10.  |                               |                    |
|               |                               | - Apply a hydrogel to all                                      |              |      | What systems were put in place to  |                               |                    |
|               | ,                             | over with secondary dressing                                   |              |      | prevent the deficient practice from  |                               |                    |
|               |                               | cy of dressing changes per                                     |              |      | reoccurring:   |                               |                    |
|               | the discretion of the         |  |              |      | , and the second |                               |                    |
|               |                               | ounds with necrosis - Santyl                                   |              |      | On 8/18/16 the DON in-serviced the MI  | DS                            |                    |
|               |                               | nded for debridement.  |              |      | Nurses related to pressure ulcers being  | ,                             |                    |
|               |                               | lmitted on 6/16/2016. The                                      |              |      | included in resident□s plan of care. On  |                               |                    |
|               | admission assessm             | ent indicated the presence of                                  |              |      | 8/18/16 an in-service for all RN□s and   |                               |                    |
|               | a reddened are with           | a possible opening on the                                      |              |      | LPN□s was initiated by DON related to  | )                             |                    |
|               | coccyx. There was             | no measurements or wound                                       |              |      | completing resident treatments as  |                               |                    |
|               | staging provided on           | this assessment.   |              |      | ordered, staging of wounds, interventio  | ns,                           |                    |
|               | A review of the Mini          | imum Data Set (MDS)  |              |      | and MD/RP notification, and the wound  |                               |                    |
|               |                               | ent dated 6/29/2016 indicated                                  |              |      | care protocol including Stage 2 (Partial   |                               |                    |
|               |                               | tage 2 pressure ulcer, with                                    |              |      | thickness skin loss)   If wound has sm   |                               |                    |
|               |                               | oresent on admission.  |              |      | to moderate amount of drainage apply   | а                             |                    |
|               |                               | e plan dated 7/6/2016 revealed                                 |              |      | hydrocolloid and change every seven  |                               |                    |
|               | _                             | assessments and treatments                                     |              |      | days and as needed. Stage 3 (Full  |                               |                    |
|               |                               | ician or per protocol to sacrum                                |              |      | thickness tissue loss) and Stage 4 (Ful  |                               |                    |
|               |                               | ventions. There were no other                                  |              |      | thickness tissue loss with exposed bon   |                               |                    |
|               |                               | e plan as the condition of the                                 |              |      | tendon, or muscle) - Apply a hydrogel t  |                               |                    |
|               |                               | ogressed to an unstageable                                     |              |      | all wound surfaces. Cover with second  | •                             |                    |
|               |                               | lan did refer to the skin care ned interventions at different  |              |      | dressing of choice. Frequency of dress   | ing                           |                    |
|               | · .                           | ied interventions at dilierent                                 |              |      | changes per the discretion of the Treatment Nurse. Stage 3 or 4 wounds   |                               |                    |
|               | wound stages.                 | tment record showed that                                       |              |      | with necrosis -Santyl dressing   | ſ                             |                    |
|               |                               | ngs were applied beginning                                     |              |      | recommended for debridement. On  | ĺ                             |                    |
|               |                               | eference to wound size or                                      |              |      | 8/18/16 an in-service for all RN s and   |                               |                    |
|               |                               | d to be changed every seven                                    |              |      | LPN□s was initiated by DON related to  |                               |                    |
|               | days or as needed.            | 9  |              |      | wound ulcer flow sheets and flow shee  |                               |                    |
|               |                               | nding Orders signed at   |              |      | non-ulcer skin sheets. In servicing will   |                               |                    |
|               |                               | uded wound care protocol,                                      |              |      | 100 % complete by 8/22/16. No staff w  |                               |                    |
|               |                               | or different physician orders                                  |              |      | be allowed to work a shift after 8/22/16   |                               |                    |

Facility ID: 923017

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   |  | (X2) MUL<br>A. BUILDI |     | (X3) DATE SURVEY<br>COMPLETED   |   |                            |
|---|---|--|-----------------------|-----|---|---|----------------------------|
|   |   |  | 7 50.25               | _   | <del></del>   | (   | 2                          |
|   |   | 345144   | B. WING               |     |   | l '   | 28/2016                    |
| NAME OF P   | ROVIDER OR SUPPLIER   |  |                       | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |   |                            |
| DINE DID  | CE UEALTH AND DEHA  | DIL ITATION CENTED   |                       | 70  | 06 PINEYWOOD ROAD   |   |                            |
| PINE KID  | GE HEALTH AND REHA  | BILITATION CENTER  |                       | Т   | HOMASVILLE, NC 27360  |   |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG    |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)   |   | (X5)<br>COMPLETION<br>DATE |
| F 282   | until 7/22/2016. On 7/22/2016 a chanoted with a wound the treatment record and measurements hydrogel dressing with to be changed every A review of the nursi was no wound assessmented on the treatmenthere were no indicated monitoring the skin from the wound care protocol initiation of treatmenthere were no measurements made to pressure ulcer to a separate was interviewed. She scheduled on the floto wound care for the who was responsible explained that the nuresponsible for wour On 7/27/2016 at 4:15. Resident #2 was interviewed. She did the dressing but no one had ever do measurements. On 7/27/2016 at 4:25 for evenings was interviewed in the floto wound care for the whole was responsible for wour on 7/27/2016 at 4:15. Resident #2 was interviewed. On 7/27/2016 at 4:25 for evenings was interviewed was interviewed. | Resident #2 pressure ulcer ange in the treatment was assessment documented on I of Stage 4 with black eschar of 4 cm x 3 cm x 1 cm. A as implemented at this time I three days or as needed. Ing notes indicated that there essments between the eent and the assessment eent record on 7/22/2016. ations that nursing staff were for changes as outlined in the I and the care plan. From the I and the care plan. From the I and the care plan the I and the record on 7/22/2016 urements documenting the wound from a stage 2 stage 4. The Treatment or dindicated there were no to the treatment of the effined in the wound care I opm, the wound care nurse the indicated that she was for instead of being assigned the last month. When asked the for wound care she urses on the halls were the care for their residents. The providence of the presidents to pm, the nurse caring for the providence of the providents that the same care of the providents that the same care of the providents that the provid | F                     | 282 | until all in-services have been completed. All new hires will receive in-services during new employee orientation.  On 8/22/16 a wound meeting was held with the RD,DON,QI, Treatment Nurse attendance and will continue to be held weekly x 12 weeks then monthly x 3.  How the facility will monitor systems purplace:  All resident□s with pressure ulcers care plan, intervention, and weekly assessments will be audited using the wound QI tool during each facility wound meeting. A wound meeting was held on 8/22/16 with the RD,QI,DON, Treatmer nurse in attendance and will continue to be held weekly x 12 weeks then month 3.  The monthly QI committee will review the results of the Wound QI audit tool monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrate and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive Quarterly execu | in  It in  e  Ind  Int  D  It in  O  It in  A |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |                     | (X3) DATE SURVEY<br>COMPLETED  |        |                            |
|--|--|---|---------------------|--|--------|----------------------------|
|  |  | 345144  | B. WING _           |  |        | C<br>/ <b>28/2016</b>      |
|  | ROVIDER OR SUPPLIER<br>GE HEALTH AND REHAE   | BILITATION CENTER   | •                   | STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD THOMASVILLE, NC 27360                           |        |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE | (X5)<br>COMPLETION<br>DATE |
| F 282  | indicated that the wor<br>and that the nurses of<br>responsible for wound<br>On 7/28/2016 at 10:00<br>and care was observed<br>care physician and the<br>physician explained to<br>Measurements were<br>and noted to be 7 cm<br>depth due to eschar.<br>unstageable, but would<br>after debridement.<br>After the wound care<br>the wound care nurse<br>explained that she has<br>wound care because<br>of residents most of to<br>if the lack of wound at<br>the wound progression<br>indicated that it had, of<br>interventions that were<br>have been implement<br>On 7/28/2016 at 3:42 | and nurse would do those in the hall would not be did measurements. 9 am, wound assessment ed with the consulting wound e wound care nurse. The hat it needed debriding. completed by the physician in x 5 cm x 1 cm, estimated. He indicated that it was all did probably be a stage 4. The was interviewed. She was interviewed. She indicated that it was assigned to a hall the last month. When asked in for Resident #2, she explaining further that the recidentified today could. | F2                  | 82   |        |                            |
| F 314<br>SS=G  | three weeks the wour assigned to wound care nurse for resider be covered, and she do their own wound of would include assess 483.25(c) TREATMED PREVENT/HEAL PRIBASED on the compreresident, the facility many who enters the facility does not develop pre  | nd care nurse was not are. She used the wound not care, so the halls would expected the floor nurses to are. She indicated that ing wounds.   | F3                  | 14   |        | 8/22/16                    |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X' |  | I DENTIFICATION NUMBED:   |                     |     | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED          |                            |
|---|--|---|---------------------|-----|--|--|----------------------------|
|   |  | 345144  | B. WING _           |     |  |  | 28/2016                    |
| NAME OF PI  | ROVIDER OR SUPPLIER  |   | 1                   | STF | REET ADDRESS, CITY, STATE, ZIP CODE  | 1 077                                  | 20/2010                    |
|   |  |   |                     | 706 | 6 PINEYWOOD ROAD   |  |                            |
| PINE RIDO   | SE HEALTH AND REHAE  | BILITATION CENTER   |                     | TH  | IOMASVILLE, NC 27360   |  |                            |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFI)<br>TAG | ×   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   |  | (X5)<br>COMPLETION<br>DATE |
| F 314   | Continued From page  | e 9   | F3                  | 314 |  |  |                            |
|   | they were unavoidable pressure sores receive   | le; and a resident having<br>ves necessary treatment and<br>nealing, prevent infection and  |                     |     |  |  |                            |
|   | by: Based on record revinterviews and physic failed to accurately as of a pressure ulcer, was unstageable pressure residents (Resident # ulcers. The findings included Resident #2 was admidiagnoses of stage 4 Alzheimer's dement An admission skin as the admitting nurse or reddened area with particular coccyx. No measure on this assessment. A review of the Minimadmission assessment the presence of a stagranulation tissue, produced interventions included incontinent care, wou supplements as order assessments. | nitted on 6/16/2016 with chronic kidney disease, ia and type II diabetes. sessment was completed by n 6/26/2016, which noted a ossible opening on the ments or staging were noted num Data Set (MDS) nt dated 6/29/2016 indicated ge 2 pressure ulcer, with esent on admission. blan dated 7/6/2016 nt #2 had a pressure ulcer d turning and positioning, |                     |     | Ftag 314 Treatments  What measures did the facility put in pl for the resident affected:  On 7/26/16 resident #2□s wound was assessed by MDS Nurse. On 7/26/16 a referral was made to the wound doctor MDS Coordinator. On 7/28/16 a wound ulcer flow sheet was completed for resident #2 by the treatment nurse. Resident #2 was seen by wound doctor on 7/28/16. New treatment orders were received by the wound doctor. On 7/28 the resident RP was made aware of condition of wound and new orders received by Treatment Nurse. On 7/28/16 the new orders were transcriberesident #2□s TAR and initiated. On 7/28/16 an air mattress was applied to resident bed. On 7/31/16 resident #2 has a Foley catheter placed by staff nurse physician order.  What measures were put in place for residents having the potential to be affected: | a<br>by<br>d<br>r<br>e<br>d/16<br>d to |                            |
|   | was to be applied eve  | a dressing of hydrocolloid<br>ery 7 days and as needed,<br>d for the application and no<br>ents were indicated.   |                     |     | On 8/22/16 a 100% skin audit was completed on all residents by the MDS Nurse, QI and DON for new skin  | }                                      |                            |

| CENTER        | S FOR MEDICARE &              | MEDICAID SERVICES   |              |     |  | CIVID INC         | <del>7. 0930-0391</del> |
|---------------|-------------------------------|---|--------------|-----|--|-------------------|-------------------------|
|               | OF DEFICIENCIES<br>CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:          | ` ′          |     | CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED         |
|               |                               |   |              |     |  | (                 | 0                       |
|               |                               | 345144  | B. WING _    |     |  | l                 | 28/2016                 |
| NAME OF P     | ROVIDER OR SUPPLIER           | 1   |              | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |                   |                         |
|               |                               |   |              | 70  | 06 PINEYWOOD ROAD  |                   |                         |
| PINE RIDO     | GE HEALTH AND REHA            | BILITATION CENTER   |              | TI  | HOMASVILLE, NC 27360   |                   |                         |
| (X4) ID       | SUMMARY S                     | TATEMENT OF DEFICIENCIES                                    | ID           |     | PROVIDER'S PLAN OF CORRECTION  |                   | (X5)                    |
| PREFIX<br>TAG | (EACH DEFICIENC               | CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREFI<br>TAG | ×   | (EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                   | COMPLETION<br>DATE      |
| F 314         | Continued From pag            | e 10  | F;           | 314 |  |                   |                         |
|               |                               | as started on 7/9/2016 to                                   |              |     | conditions, skin referrals created,  |                   |                         |
|               |                               | essing daily and as needed to                               |              |     | treatment initiated, physician and   |                   |                         |
|               | a busted blister on th        |   |              |     | responsible party are notified with  |                   |                         |
|               |                               | s treatment record indicated a                              |              |     | documentation in the clinical record to  |                   |                         |
|               |                               | 4 measuring 4 centimeter                                    |              |     | include Wound Ulcer Flow Sheet,  |                   |                         |
|               | _                             | o sacrum with black eschar,                                 |              |     | Non-Ulcer Flow sheets and Treatment  |                   |                         |
|               |                               | saline and cover with a                                     |              |     | Record as indicated. On 8/22/16 100%   | of                |                         |
|               | hydrogel dressing sta         | arting on 7/22/2016. The                                    |              |     | all existing skin conditions were assess   | sed               |                         |
|               | previous dressing for         | -   |              |     | by MDS Nurse and DON for worsening   |                   |                         |
|               | discontinued at this t        | ime. A referral for the wound                               |              |     | with appropriate interventions put in pla  | ace,              |                         |
|               | care physician to eva         | aluate was also noted at this                               |              |     | and MD/RP notification. On 8/22/16   |                   |                         |
|               | time. Treatments we           | ere documented as   |              |     | wound ulcer flow sheets were complete  | ed                |                         |
|               | completed.                    |   |              |     | to include staging, measurements,  |                   |                         |
|               |                               | ng notes revealed a care                                    |              |     | signs/symptoms of infection, wound   |                   |                         |
|               | 1 *                           | ed 7/26/2016 at 12:16 pm, by                                |              |     | description, RP/MD notification and  |                   |                         |
|               |                               | ch identified an unstageable                                |              |     | current treatment. On 8/22/16 a 100%   |                   |                         |
|               | ·                             | neasurements of 6 cm x 5                                    |              |     | audit of all TARs was completed by   |                   |                         |
|               | · ·                           | nine depth. A description of lar with thick dark eschar     |              |     | 8/22/16 to ensure all existing skin conditions have treatments in place. C           | )n                |                         |
|               |                               | ound bed, surrounding                                       |              |     | 8/22/16 a wound meeting was held with  |                   |                         |
|               |                               | to the slightest touch, no                                  |              |     | the RD,DON,QI, Treatment Nurse.  | 1                 |                         |
|               |                               | The note indicated that a                                   |              |     | Starting 8/22/16 a staff member or   |                   |                         |
|               |                               | vith serous drainage was                                    |              |     | members will be assigned to complete   |                   |                         |
|               | _                             | ident was placed on the                                     |              |     | resident treatments daily as ordered   |                   |                         |
|               |                               | a wound care referral.                                      |              |     | What systems were put in place to  |                   |                         |
|               |                               | otes revealed a dietary                                     |              |     | prevent the deficient practice from  |                   |                         |
|               |                               | ed on 7/26/2016. The  |              |     | reoccurring:   |                   |                         |
|               | assessment indicate           | d that the resident consumed                                |              |     | On 8/18/16 an n-service for all RN□s a   | and               |                         |
|               | 45% of her meals on           | average with full staff                                     |              |     | LPN□s was initiated by DON related to  | )                 |                         |
|               | assistance for the las        | st 4 days. Dietary  |              |     | completing treatments as ordered, wou  | ınd               |                         |
|               | supplements were no           | oted as a frozen dietary                                    |              |     | ulcer flowsheets and flowsheet of  |                   |                         |
|               |                               | hree times a day and a                                      |              |     | non-ulcer skin sheets, TARS, and skin  |                   |                         |
|               |                               | etween meals and at night.                                  |              |     | referrals will be 100% complete by   |                   |                         |
|               |                               | ied the presence of a sacral                                |              |     | 8/22/16. On 8/18/16 an in-service was  |                   |                         |
|               | wound with eschar.            |   |              |     | initiated for all RN□s and LPN□s by the  | е                 |                         |
|               |                               | ) pm the wound care nurse                                   |              |     | DON related to s/s of infection of a   |                   |                         |
|               |                               | e indicated that she has                                    |              |     | wound, to include 1) induration, 2) feve   |                   |                         |
|               |                               | he floor instead of being                                   |              |     | 3) erythema, 4) edema, 5) increased p  | ain               |                         |
|               | assigned to wound c           | are. She explained that she                                 |              |     | at the wound site, 6) increased WBC  |                   |                         |

| (X1)   | PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | I ' '  |  |  |   | (X3) DATE SURVEY<br>COMPLETED   |  |
|--|--|--|--|--|---|---|--|
|  |  | A. BUILDI  | NG _   |  | ,   | _   |  |
|  | 345144   | B. WING  |  |  | l   | 28/2016   |  |
| PLIER  |  | ,  | S  | TREET ADDRESS, CITY, STATE, ZIP CODE   |   |   |  |
| D DELLA DILLE  | ATION OFNITED  |  | 70   | 06 PINEYWOOD ROAD  |   |   |  |
| D KEHABILI I   | ATION CENTER   |  | T  | HOMASVILLE, NC 27360   |   |   |  |
| DEFICIENCY MU  | ST BE PRECEDED BY FULL   |  | X  | ,  |   | (X5)<br>COMPLETION<br>DATE  |  |
| assigned to explained the and another in taking a har asked who is blained that the did to do their asked about it the nurses do the week responsible frecond shift of at 3:16 pm She explain 's room to de Change of doing. She assessment e a nurse har be a stage II e to a blister I and that no is with measure it she knew to re on Thursd resident #2 with a taken the condition of t | at one nurse had been nurse was gone and II assignment since is responsible for wound he nurses on the halls own resident's wound the assessments, she on the hall are by assessments as well. For the even number ones the odd number of the odd number | F  | 314  | count, 7) foul smelling, purulent wound drainage, 8) decreased appetite, 9) general malaise, 10) failure to heal or sudden worsening of wound, staging or wounds, interventions, and MD/RP notification, will be 100% by 8/22/16. O 8/18/16 an in-service for all CNA and medication aides by DON related to notification to nurse of new skin conditionserved and dressings being off or saturated and will be 100% complete be 8/22/16. On 8/22/16 the treatment Nursewas in-serviced by DON related to completing treatments as ordered, TAF skin referrals, completion of wound uld flowsheets and flowsheet of non-ulcer skin sheets (how to complete and must completed every 7 days), notification of MD and RP of new areas and worsenir of areas. On 8/16/16 the director of nursing, nursing supervisors, and all on-call nurses were in-serviced by the administrator that a staff member or members must be assigned to complet treatments daily as ordered No staff be allowed to work after 8/22/2016 untiin-services are completed. All new hire will receive in-services during new employee orientation.  On 8/22/16 a wound meeting was held with the RD,DON,QI and Treatment Nuin attendance and will continue to be howeekly.  | n d on y se ss, ser se be fing e will I s   |   |  |
|  | IMMARY STATEM DEFICIENCY MU ATORY OR LSC III or assigned to explained that and another n taking a ha asked who is blained that the d to do their asked about at the nurses do the week responsible for econd shift do to do their asked about at the nurses do the week responsible for econd shift do to do their asked about at the nurses do the week responsible for econd shift do to do their asked about at the nurse and that no swith measure a nurse har be a stage II et to a blister of and that no swith measure and that no swith measure at she knew the contract of the nurse in the that there are the that there are the had the old and the symmetry and  | IDENTIFICATION NUMBER:  345144  PPLIER  ID REHABILITATION CENTER  IMMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) | IDENTIFICATION NUMBER:  345144  B. WING  WINC  WINC  WING  WINC  W | IDENTIFICATION NUMBER:  345144  B. WING  PILIER  ID REHABILITATION CENTER  ID PREFIX TAG  TOM page 11  In assigned to wound care for the last explained that one nurse had been and another nurse was gone and in taking a hall assignment since asked who is responsible for wound olained that the nurses on the halls do to their own resident's wound asked about the assessments, she at the nurses on the hall are do the weekly assessments as well. responsible for the even number econd shift does the odd number  6 at 3:16 pm the MDS nurse was She explained that she went in 's room to do a wound assessment econd shift does the odd number  6 at assessment was on the treatment er a nurse had noted a busted blister be a stage II ulcer. She verified that the last assessment was on the treatment er on Thursday and she wanted to desident #2 was seen.  6 at 4:15 pm the nurse caring for was interviewed. She indicated that the dressing change as expected last explained that the nurse aide came to her that there was no dressing on. The nurse indicated that the wound ck and necrotic with a foul odor. She at she had the resident when she nitted and the skin was just red, but lack. She that she does not do sements and measurements. She | PILER  345144  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  766 PINEYWOOD ROAD THOMASVILLE, NC 27360  ID PROVIDER'S PLAN OF CORRECTION MARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION)  Tom page 11  In assigned to wound care for the last explained that one nurse had been and another nurse was gone and in taking a hall assignment since asked who is responsible for wound blained that the nurses on the halls d to do their own resident's wound saked about the assessments, she at the nurses on the hall are do the weekly assessments as well. responsible for the even number econd shift does the odd number  6 at 3:16 pm the MDS nurse was She explained that the last assessment was on the treatment e a nurse had noted a busted bilster be a stage II ulcer. She verified that te to a bilster was the last assessment and that no formal skin swith measurements existed. She at she knew the wound care doctor re on Thursday and she wanted to tesident #2 was seen. 6 at 4:15 pm the nurse caring for was interviewed. She indicated that the dressing change as expected last explained that the nurse aide came to her that there was no dressing on Then nurse indicated that the wound ck and necrotic with a foul odor. She at she had the resident when she nitted and the skin was just red, but lack. She that she does not do ssments and measurements. She | A BUILDING  345144  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 766 PINEYWOOD ROAD THOMASVILLE, NC. 27360  IMMARY STATEMENT OF DEFICIENCIES  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED OF THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL A assigned to wound care for the last explained that one nurse had been and another nurse was gone and n taking a hall assignment since asked who is responsible for wound alained that the nurses on the halls d to do their own resident. 'Is wound asked about the assessments, she it the nurses on the hall are d to the weekly assessments as well. responsible for the even number econd shift does the odd number d can also the deal of the even number econd shift does the odd number d can are had noted a busted bilster a change of Therapy assessment a change of Therapy assessment a change of Therapy assessment a doing. She explained that the last assessment was on the treatment a change of Therapy assessment a doing. She explained that the last assessment was on the treatment a change of Therapy assessment and that no formal skin swith measurements existed. She is the knew the wound care doctor re on Thursday and she wanted to tesident #2 was seen. 6 at 4:15 pm the nurse caring for was interviewed. She indicated that the cressing change as expected last xyplained that the rurse aide came to her that there was no dressing on The nurse indicated that the wound ck and necrotic with a foul odor. She at she had the resident when she nitted and the skin was just red, but lack. She that she does not do symments and measurements. She |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MUL<br>A. BUILDI |                    | CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED    |  |
|---|--|--|-----------------------|--------------------|--|-------------------|--------------------|--|
|   |  |  | A. BOILD              | NG _               |  | ,                 | _                  |  |
|   | <b>345144</b> B. WING  |  |                       | C<br>07/28/2016    |  |                   |                    |  |
| NAME OF PROVIDER OR SUPPLIER                        |  |  |                       | S                  | TREET ADDRESS, CITY, STATE, ZIP CODE   |                   |                    |  |
|   |  |  |                       | 706 PINEYWOOD ROAD |  |                   |                    |  |
| PINE RIDO   | SE HEALTH AND REHAE  | BILITATION CENTER  |                       | Т                  | HOMASVILLE, NC 27360   |                   |                    |  |
| (X4) ID   | SUMMARY ST   | ATEMENT OF DEFICIENCIES  | ID                    |                    | PROVIDER'S PLAN OF CORRECTION  |                   | (X5)               |  |
| PRÉFIX<br>TAG                                       |  | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | PREFI<br>TAG          |                    | (EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                   | COMPLETION<br>DATE |  |
| F 314   | Continued From page  | e 12   | F                     | 314                |  |                   |                    |  |
|   | She indicated that sh  | e would do the dressings as  |                       |                    | On 8/19/16 the MDS nurse, QI nurse a   | nd                |                    |  |
|   |  | gs but no one has ever told  |                       |                    | or DON began auditing 100% of reside   |                   |                    |  |
|   | her that she needed  | to do measurements.  |                       |                    | progress notes for any acute changes   | :О                |                    |  |
|   | On 7/27/2016 at 4:29   | pm the nurse supervisor for  |                       |                    | include new or worsening of skin   |                   |                    |  |
|   | evenings was intervie  | ewed. She explained that   |                       |                    | conditions using the Chart audit tool. C   |                   |                    |  |
|   |  | sible for the odd number   |                       |                    | 8/19/16 the MDS nurse, QI and or DON   |                   |                    |  |
|   |  | es. When asked about   |                       |                    | began auditing 100% of the TARS, wou   |                   |                    |  |
|   |  | and measurements, she  |                       |                    | ulcer flow sheets, flow sheets of non-ul   | cer               |                    |  |
|   | indicated that the wound nurse would do those  |  |                       |                    | conditions and skin referrals for  | _                 |                    |  |
|   | and that the nurses on the hall would not be   |  |                       |                    | completion and accuracy using the TAF  |                   |                    |  |
|   | responsible for wound measurements.  |  |                       |                    | audit tool. A The Treatment nurse, or F  |                   |                    |  |
|   | On 7/28/2016 at 10:09 am wound assessment  |  |                       |                    | nurses will conduct a skin audit of 10%  | OI                |                    |  |
|   | and care was observed with the consulting wound care physician and the wound care nurse. The |  |                       |                    | the residents and observations for any acute change in condition 2x a week x         | 4                 |                    |  |
|   |  | in an upright position in bed  |                       |                    | weeks, then weekly x 4 weeks, then   | <b>"</b>          |                    |  |
|   |  | f. The physician instructed  |                       |                    | monthly x 1 month using a Chart Audit  |                   |                    |  |
|   |  | e to make sure she was   |                       |                    | Tool to ensure any new or worsening s  |                   |                    |  |
|   |  | han 30 degrees due to the  |                       |                    | abnormalities to include pressure ulcer  |                   |                    |  |
|   | _  | n would put on her back. He  |                       |                    | have been identified, skin referrals   |                   |                    |  |
|   | also recommended a   | n air mattress to relieve  |                       |                    | created, treatment initiated, physician a  | ind               |                    |  |
|   | some of the pressure   | while in bed. The resident   |                       |                    | responsible party are notified with  |                   |                    |  |
|   | was lowered and turr   | ned to her side. The   |                       |                    | documentation in the clinical record to  |                   |                    |  |
|   | dressing was remove  | ed. A strong foul odor was   |                       |                    | include Wound Ulcer Flow Sheet,  |                   |                    |  |
|   |  | n explained that the smell   |                       |                    | Non-Ulcer Flow sheets and Treatment  |                   |                    |  |
|   |  | sue. He tapped the eschar  |                       |                    | Record as indicated. Any concerns will   |                   |                    |  |
|   | and noted that it was  |  |                       |                    | addressed immediately by the treatment   | nt                |                    |  |
|   | explained that it need   | _  |                       |                    | nurse or RN/LPN nurse with an  |                   |                    |  |
|   |  | completed by the physician   |                       |                    | assessment of the skin abnormality,  |                   |                    |  |
|   |  | x 5 cm x 1 cm, estimated   |                       |                    | initiation of treatment, creation of a Skii  |                   |                    |  |
|   |  | The physician explained  |                       |                    | Referral, notification of the physician ar   |                   |                    |  |
|   | that it would probably   |  |                       |                    | responsible party, and documentation of findings in the clinical record to include   |                   |                    |  |
|   | debridement. Debridement was attempted by the  |  |                       |                    | Wound Ulcer Flow Sheet, Non-Ulcer Fl   |                   |                    |  |
|   | physician with a large amount of black substance removed from the wound bed. The physician   |  |                       |                    | Sheet, and Treatment Record. All audi  |                   |                    |  |
|   | explained that he was not able to get it all today   |  |                       |                    | will be completed 2x a week x 4 weeks  |                   |                    |  |
|   |  | ack next Thursday to do the  |                       |                    | then weekly x 4 weeks, then monthly x  |                   |                    |  |
|   | rest.  | in the state of th |                       |                    | month.   | -                 |                    |  |
|   |  | 2 am the wound care nurse  |                       |                    |  |                   |                    |  |
|   |  | ng the dressing to Resident  |                       |                    | The DON will present findings at the   |                   |                    |  |

| STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` '                 |                   | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|--|---|--|---------------------|-------------------|---|-------------------------------|----------------------------|--|
|  |   |  |                     |                   |   |                               | С                          |  |
|  |   | 345144   | B. WING _           | B. WING           |   |                               | 28/2016                    |  |
| NAME OF P  | ROVIDER OR SUPPLIER   |  |                     | S                 | TREET ADDRESS, CITY, STATE, ZIP CODE  |                               |                            |  |
|  |   |  | 70                  | 06 PINEYWOOD ROAD |   |                               |                            |  |
| PINE RID   | GE HEALTH AND REH   | ABILITATION CENTER   |                     | Т                 | HOMASVILLE, NC 27360  |                               |                            |  |
| (X4) ID<br>PREFIX<br>TAG                             | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)                  |  | ID<br>PREFII<br>TAG | X                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)  |                               | (X5)<br>COMPLETION<br>DATE |  |
| F 314  | Continued From pa   | age 13   | F 3                 | 314               |   |                               |                            |  |
| F 314  | (EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | F                   | 314               | quarterly Executive QI Committee meeting for further recommendations follow up as needed or continued compliance in this area and to determithe need for and/or frequency of the continued QI monitoring. |                               |                            |  |
|  | keep the urine from<br>explained she wou<br>interventions and of<br>physician to put the<br>Staffing for June and<br>Beginning in June, | n soaking the wound. She Id have been aware of these communicated them to the em into place. |                     |                   |   |                               |                            |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                   |     | CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY<br>LETED            |
|---|---|--|-------------------|-----|---|-------------------|----------------------------|
|   |   | 245444   |                   |     |   | С                 |                            |
| NAME OF D   |   | 345144   | B. WING           |     | TREET ARRESTO OUTV STATE 710 OORE   | 07/               | 28/2016                    |
| NAME OF PROVIDER OR SUPPLIER  PINE RIDGE HEALTH AND REHABILITATION CENTER |   |  |                   | 70  | TREET ADDRESS, CITY, STATE, ZIP CODE D6 PINEYWOOD ROAD HOMASVILLE, NC 27360   |                   |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| F 353<br>SS=G   | to wound care only 4 On 7/28/2016 at 3:42 was interviewed. She three weeks the woun assigned to wound ca vacation and for two take a hall. She expl. She staffed the floor is so the halls would be floor nurses to do the indicated that would i 483.30(a) SUFFICIEI PER CARE PLANS  The facility must have provide nursing and in maintain the highest and psychosocial wel determined by reside individual plans of ca.  The facility must provinumbers of each of the personnel on a 24-ho care to all residents in care plans:  Except when waived section, licensed nurs personnel.  Except when waived section, the facility misside in Except when waived | and care nurse was assigned days.  pm the Director of Nursing to explained that for the last and care nurse was not the last are. One week she was on weeks she was assigned to ained that it was necessary. With the wound care nurse covered and expected the ir own wound care. She include assessing wounds.  NT 24-HR NURSING STAFF  The sufficient nursing staff to elated services to attain or practicable physical, mental, albeing of each resident, as int assessments and ire.  The following types of our basis to provide nursing in accordance with resident aunder paragraph (c) of this |                   | 314 |   |                   | 8/22/16                    |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                               | ` '                |                                | CONSTRUCTION   |       | (3) DATE SURVEY<br>COMPLETED |  |  |  |
|---|--|--|--------------------|--------------------------------|--|-------|------------------------------|--|--|--|
|   |  |  |                    |                                |  | С     |                              |  |  |  |
|   |  | 345144   | B. WING            |                                |  |       | 28/2016                      |  |  |  |
| NAME OF PROVIDER OR SUPPLIER                        |  |  |                    | S                              | TREET ADDRESS, CITY, STATE, ZIP CODE   | 1 077 | 20/2010                      |  |  |  |
|   |  |  |                    |                                | 06 PINEYWOOD ROAD  |       |                              |  |  |  |
| PINE RIDO   | SE HEALTH AND REHAE  | BILITATION CENTER  |                    |                                | HOMASVILLE, NC 27360   |       |                              |  |  |  |
|   | OUNDANDY OTATEMENT OF DEFICIENCIES   |  |                    |                                | PROVIDER'S PLAN OF CORRECTION  |       | 0/5)                         |  |  |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION) | ID<br>PREFI<br>TAG |                                | (EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |       | COMPLETION<br>DATE           |  |  |  |
| F 353   | Continued From page 15   |  |                    | 353                            | 53   |       |                              |  |  |  |
|   |  | Γ is not met as evidenced  |                    |                                |  |       |                              |  |  |  |
|   | by:  | The flot met de evidenced  |                    |                                |  |       | E DATE                       |  |  |  |
|   | · ·  | iew, observations, staff and   |                    |                                | FTag 353 staffing  |       |                              |  |  |  |
|   |  | the facility failed to provide   |                    |                                |  |       |                              |  |  |  |
|   | adequate staffing to p   | provide skin assessments   |                    |                                | What measures did the facility put in pl   | ace   |                              |  |  |  |
|   |  | gement for 1 of 3 residents  |                    |                                | for the resident affected:   |       |                              |  |  |  |
|   | •  | ed for pressure ulcers. This   |                    |                                |  |       |                              |  |  |  |
|   | tag is cross referenced to F 314.  |  |                    |                                |  |       |                              |  |  |  |
|   | The findings included:   |  |                    |                                | On 8/22/16 the Administrator (Adm) an  |       |                              |  |  |  |
|   | F 314 Based on record review, observation, staff   |  |                    |                                | the Director of Nursing(DON) reviewed  |       |                              |  |  |  |
|   | interviews and physician interview the facility  |  |                    |                                | the staffing schedule to ensure sufficient numbers of staff to provide nursing car   |       |                              |  |  |  |
|   | failed to accurately assess and oversee treatment of a pressure ulcer, which progressed        |  |                    |                                | to all residents to include completing all   |       |                              |  |  |  |
|   | to an unstageable pressure ulcer with eschar, for  |  |                    |                                | resident treatments treatments in  | '     |                              |  |  |  |
|   | 1 of 3 residents (Resident #2) reviewed for  |  |                    |                                | accordance with resident care plans  |       |                              |  |  |  |
|   | pressure ulcers.   |  |                    |                                | What measures were put in place for  |       |                              |  |  |  |
|   | An interview with the Director of Nursing on   |  |                    |                                | residents having the potential to be   |       |                              |  |  |  |
|   | 7/28/2016 at 3:42 pm   | revealed that to cover the   | affected:          | affected:                      |  |       |                              |  |  |  |
|   | resident halls with su   | fficient nursing staff the   |                    |                                |  |       |                              |  |  |  |
|   |  | d been assigned to care for  |                    |                                |  |       |                              |  |  |  |
|   | a hall of residents ins  |  |                    | On 8/22/16 the Adm and the DON |  |       |                              |  |  |  |
|   |  | many of the days the wound   |                    |                                | reviewed the current schedule of staffin   | ıg    |                              |  |  |  |
|   | care nurse was assigned to the hall there were only 3 nurses and two med aides to care for all |  |                    |                                | to ensure sufficient numbers of staff to   |       |                              |  |  |  |
|   |  |  |                    |                                | provide nursing care to all residents to include all resident treatments in          |       |                              |  |  |  |
|   | five halls, so the nurses would cover their own hall of about 30 residents and one of the med  |  |                    |                                | accordance with resident care plans in   | the   |                              |  |  |  |
|   | aide 's halls for abou   |  |                    |                                | next week. Starting 8/19/16 a staff  | u IC  |                              |  |  |  |
|   |  | s open positions for staff   |                    |                                | member or members will be assigned to  |       |                              |  |  |  |
|   |  | restorative and rehab nurse  |                    |                                | complete resident treatments daily as  |       |                              |  |  |  |
|   |  | The MDS nurse will start   |                    |                                | ordered.   |       |                              |  |  |  |
|   | next week. She explained that she has hired two  |  |                    |                                |  |       |                              |  |  |  |
|   | -  | d two licensed practical   |                    |                                | On 8/22/16, the Administrator met  |       |                              |  |  |  |
|   |  | d that when they were  |                    |                                | with/notified the Regional Vice Preside  |       |                              |  |  |  |
|   |  | uld be covered. She also   |                    |                                | (RVP) of currently facility staffing need  | s to  |                              |  |  |  |
|   | explained that the wo  |  |                    |                                | provide nursing care to all residents in   |       |                              |  |  |  |
|   | resigned with her last   |  |                    |                                | accordance with resident care plans.   |       |                              |  |  |  |
|   |  | ner position was open as   |                    |                                | What systems were put in place to  |       |                              |  |  |  |
|   |  | hat they had lost two nurses,  |                    |                                | prevent the deficient practice from  |       |                              |  |  |  |
| one sick and one had to be                          |  | I to be let go. She identified   |                    |                                | reoccurring:   |       | 1                            |  |  |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL <sup>-</sup><br>A. BUILDI |                       | CONSTRUCTION   |  | (X3) DATE SURVEY<br>COMPLETED |  |  |
|---|--|--|------------------------------------|-----------------------|--|--|-------------------------------|--|--|
|   |  | 0.5444   | D WING                             | B WING                |  |  | С                             |  |  |
|   |  | 345144   | B. WING                            | B. WING               |  | 07/  | 28/2016                       |  |  |
| NAME OF P   | ROVIDER OR SUPPLIER  |  |                                    | S                     | TREET ADDRESS, CITY, STATE, ZIP CODE   |  |                               |  |  |
| PINE RID  | GE HEALTH AND REHAE  | RII ITATION CENTER                                 |                                    | 70                    | 06 PINEYWOOD ROAD  |  |                               |  |  |
| I IIVE IVID   | JE NEAEIN AND NENAE  | SIETATION SENTER                                   |                                    | THOMASVILLE, NC 27360 |  |  |                               |  |  |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |  | ID<br>PREFI<br>TAG                 |                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  |  |                               |  |  |
| F 353   | 1 3  |  | F                                  | 353                   |  |  |                               |  |  |
|   | (EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                |  |                                    |                       | On 8/16/16 the director of nursing, nurs supervisors, and all on-call nurses were in-serviced by the administrator that a staff member or members must be assigned to complete treatments daily. No staff will be allowed to work after 8/22/2016 until in-services are complet All new hires will receive in-services during new employee orientation.  How the facility will monitor systems puplace:  On 8/22/16, the Adm and/or the DON initiated a QI monitoring tool titled Sufficient Staff tool to monitor for suffic staff will be made based on the staff sability to provide needed care to reside that enable them to reach their highest practicable physical, mental, psychoso well-being, and including treatments be completed as ordered. The Adm and/o the DON will utilize the Sufficient Staff five times weekly to include weekends four weeks, twice weekly for four week weekly for four weeks, and monthly tim three months. Any identified issues will be addressed immediately. The Adm and/or the DON will present findings for the Sufficient Staff tool at the monthly Committee meetings for six months for further recommendations.  Beginning 8/22/16, the Adm will monitor the Sufficient Staff tool to ensure proper completion of the Sufficient Staff tool. Adm will initial the form with the date as | e ed.  ed.  ient sonts  cial eing r toool for ss, ues ull com QI |                               |  |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |   |           | (X3) DATE SURVEY<br>COMPLETED |  |  |  |
|---|---|--|-------|--|---|-----------|-------------------------------|--|--|--|
|   |   | <b>345144</b> B. WING                              |       |  | C<br>07/28/2016   |           |                               |  |  |  |
| NAME OF P   | ROVIDER OR SUPPLIER   |  |       | STREET ADDRESS, CITY, STATE, ZIP CODE  |   |           | .0/2010                       |  |  |  |
| DINE DIDCE LIEALTH AND DELIABILITATION CENTED       |   |  |       | 706 PINEYWOOD ROAD   |   |           |                               |  |  |  |
| PINE RIDGE HEALTH AND REHABILITATION CENTER         |   |  |       | THOMASVILLE, NC 27360  |   |           |                               |  |  |  |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE REGULATORY OR LSC IDENTIFYING INFORMATION)  T/ |  |       | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH   | PROVIDER'S PLAN OF CORRECTION (X5)  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)  (X5)  COMPLETI  DATE |           |                               |  |  |  |
| F 353   | Continued From page   | ge 17  | F3    | and follow-up. The administ present findings at the quart QI Committee meeting for fur recommendations for follow or continued compliance in to determine the need for an frequency of the continued C | erly Execut<br>irther<br>up as need<br>his area an<br>id/or   | led<br>id |                               |  |  |  |