STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 157		3/30/17

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

Electronically Signed | 03/24/2017

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F 157	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, and staff and family interview the facility failed to notify the physician regarding a change in a resident's condition for 1 of 1 sampled residents (Resident #2). Findings included: Resident #2 was admitted to the facility on 01/27/17 with the following diagnoses: generalized muscle weakness, altered mental status, depression, fatigue, narcolepsy, urinary tract infection (UTI), lack of coordination, and high blood pressure. Resident #2 was discharged to the hospital on 01/29/17. The admission Minimum Data Set (MDS) assessment had not been completed. The admission summary dated 01/27/17 at 8:04 PM revealed Resident #2 was admitted to the facility in a wheelchair but could ambulate with a walker most of the time. Resident #2 was incontinent and used briefs. Resident #2's blood pressure was 137/83. Resident #2 was oriented to the room, call light, and staff. Resident #2 had no complaints at that time. A nurse's note dated 01/28/17 at 2:18 AM	F 157	This plan of correction is submitted as required under state and federal law. The Plan of Correction does not constitute an admission on the part of the Facility that the findings are accurate, that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to Facility policies and procedures should be considered to be subsequent remedial measures and should be inadmissible in any proceedings on that basis. Without admitting or denying the validity or existence of the alleged noncompliance, the Facility submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or other action against the Facility or any employee, agent, officer, director or shareholder of the Facility. The Facility is utilizing this Plan of Correction as its allegation of substantial compliance as of March 30, 2017. Address how corrective action will be accomplished for those residents found to have been affected by the deficient	

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F 157	Continued From page 2 revealed Resident #2's blood pressure was 127/75. Resident #2 was alert and oriented to person, place, time and situation. There were no changes in Resident #2's mood or behavior. A nurse's note dated 01/29/17 at 12:59 AM revealed Resident #2's blood pressure was 97/59. Resident #2 was alert and oriented to person, place, time and situation. A nurse's note dated 01/29/17 at 2:06 PM revealed Resident #2's blood pressure was 108/62. Resident #2 was alert and oriented to person, place, time and situation. Resident #2 was sleepier than usual and would arouse to tactile and verbal stimuli, but fell back to sleep. A nurse's note dated 01/29/17 at 5:10 PM revealed Resident #2 had been lethargic and difficult to arouse. Resident #2 would awake to tactile and verbal stimuli but fell back to sleep easily. During awake episodes Resident #2 was oriented to self and situation but had confusion. Resident #2's family member was in the facility and stated Resident #2's level of consciousness had changed. The nurse practitioner (NP) was called and gave a verbal order to send Resident #2 to the hospital. When Resident #2 left facility she was awake. A review of the blood pressure summary revealed the following: 01/28/17 at 2:19 AM 127/75, 01/28/17 at 8:07 AM 136/72, 01/28/17 at 1:09 PM 130/70, 01/28/17 at 5:36 PM 126/72, 01/28/17 at 8:08 PM 97/59, 01/29/17 at 1:00 AM 97/59, 01/29/17 at 11:18 AM 108/62, and 01/29/17 at 2:06 PM 108/62. The transfer form dated 01/29/17 at 8:00	F 157	practice. Resident was sent to the ER per the family's request and admitted. The facility cannot establish that the notification to the MD and between the staff created any negative outcome to resident #2; as she was discharged when change of status was noted. Address how corrective action will be accomplished for those having the potential to be affected by the same deficient practice. The Director of Nursing, on noting this incident had occurred, did a clinical review of all current residents' status to assure there were no miss-communicated changes in status; the Director of Nursing identified no other residents. This audit was completed on 3/17/17. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. The Director of nursing educated the nursing staff on "changes on condition" which includes proper notification prior to March 30, 2017. Indicate how the facility plans to monitor its performance to make sure the solutions are sustained. The Director of Nursing or designee will conduct a random audit of 5 residents	

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F 157	Continued From page 3 revealed the blood pressure was 108/62. An interview on 02/28/17 at 12:42 PM with Resident #2's family member revealed the family member was in the facility on 01/29/17 between 10-11 AM. The family member stated Resident #2 would awaken momentarily but was incoherent. Nurse #6 informed the family member Resident #2 did not eat breakfast. The family member attempted to feed Resident #2 but she would not arouse to eat. The family member stated at 12:30 PM, the family member tried to arouse Resident #2 but she would only wake up momentarily and spoke in incomplete sentences. The family member stated between 12:30-1:00 PM the nurse aide (NA) came into the room to check Resident #2's brief which was dry. The family member stated she told Nurse #6 about having trouble waking Resident #2. Nurse #6 told the family member she could call the on-call provider but the on-call provider may not do anything since Resident #2 was not the provider's patient. The family member stated Nurse #6 said it would be 01/30/17 before the facility's medical director would be contacted. The family member also revealed on 01/29/17 between 5-6 PM she went to the nurse's station and told Nurse #2 to call the on-call provider. The family member stated Nurse #6 told her she would call the on-call provider but the on-call provider may not change or discontinue any medications because Resident #2 was not the on-call provider's patient. The family member revealed about 5 minutes later Nurse #6 stated she called the on-call provider and received an order to send her mother to the emergency room (ER). The family member revealed she met with the director of nursing (DON) and the administrator on Monday or Tuesday after Resident #2 was admitted to the	F 157	3x/week for 4 weeks to assure that clinical changes have been communicated shift to shift for nursing if it applies and the attending physician. Random audits will continue with 3 residents 2x/week for 4 weeks then 3 residents 1x/week for 8 weeks. Results of audits will be referred to the Quality Assurance Committee for review of patterns and trends during the audit period. The QA Committee will continue to evaluate quarterly for 1 year.	

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hospital. The DON explained to the family member the facility did everything they were supposed to do and sent Resident #2 to the hospital. The family member stated the ER doctor explained to the family member Resident #2 was dehydrated and had a UTI.

An interview on 02/28/17 at 1:50 PM with NA #1 who worked on 01/27/17 revealed Resident #2 was alert, oriented and communicated her needs. Resident #2 was not groggy nor lethargic on 01/27/17.

An interview on 02/28/17 at 2:10 PM with Nurse #7 who worked on 01/27/17 revealed Resident #2 was alert and answered questions.

An interview on 03/01/17 at 11:00 AM Nurse #6 who worked the 7 AM-7 PM shift on 01/29/17 revealed Resident #2 was asleep at 7:30 AM. Nurse # 6 stated if a resident has a change of condition, vital signs were obtained and a situation, background, assessment, recommendation (SBAR) form would be filled out. She further stated depending on the severity of the change, she would notify the provider and follow their orders. Nurse #6 revealed if a change of condition was severe or critical the provider would be called right away. Nurse #6 revealed Resident #2 did not have a drastic change in condition because during Resident #2's previous admission Resident #2 slept frequently. Nurse #6 revealed Resident #2 did not have a change of condition because she was just sleepy. Nurse #6 revealed Resident #2's vital signs were good and Resident #2 would wake up and take her medications but that evening she did not want her medications. Nurse #6 revealed the family member asked Nurse #6 to call the provider.

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F 157	Continued From page 5 Nurse #6 stated after lunch the family member informed Nurse #6 that Resident #2 was more confused. Nurse #6 stated Resident #2 woke up, talked to Nurse #6 and did not seem confused. Nurse #6 stated she obtained Resident #2's vital signs which were normal. Nurse #6 told the family member Nurse #6 would call the on-call provider but could not promise the on-call provider would give an order to send Resident #2 to the ER. Nurse #6 stated between 4:30 PM-5:00 PM the family member stated she wanted Resident #2 sent to the ER. Nurse #6 stated the family member ask her only once to send her mother to the ER. Nurse #6 stated she called the on-call provider, explained Resident #2 had been sleepy and more difficult to arouse, had some confusion but her vital signs were stable. Nurse #6 stated there was no delay in sending Resident #2 to the ER because she would wake up and take her medications. Nurse #6 stated as soon as the family member wanted Resident #2 sent to the ER, nurse #6 talked to the administrator, called the on-call provider and sent Resident #2 to the ER. Nurse #6 stated the NA's did not report any change in Resident #2's condition during the shift. Nurse #6 stated she did not receive a report from the third shift nurse about any changes in Resident #2's condition. Resident #2 was sent to the hospital between 5:00 PM-6:00 PM.	F 157		
F 166 SS=D	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.	F 166		3/30/17

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(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:

(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;

(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and

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coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and

(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than

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F 166	Continued From page 8 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview and staff interviews, the facility failed to ensure the grievance investigations and resolutions were followed up on and the investigation and resolution were provided in writing to 2 of 2 sampled residents and/or their responsible parties (Residents #5 and #3). The findings included: 1. Resident #5 was admitted to the facility most recently on 05/26/16. His diagnoses included malignant neoplasm, muscle weakness, protein malnutrition, hypertension and atrial fibrillation. His most recent Minimum Data Set, a quarterly dated 11/29/16, coded him as understanding and being understood, being cognitively intact, having no behaviors, and requiring extensive assistance with most activities of daily living skills. Nursing notes dated 12/01/16 revealed that Resident #5 returned from the dentist after his dentures were adjusted. On 02/28/17 at 10:36 AM, Resident #5 approached the surveyor in the hall and complained about having no teeth. At this time he was edentulous. Review of the grievance logs revealed Resident #5 had filed 2 Complaint/Grievance Reports since December 2016 as follows: a. On 01/04/17 Resident #5 communicated with the Director of Nursing that his toenails needed to	F 166	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Concerns for Resident #3 and Resident #5 were resolved and written notification was provided to the resident or their responsible party. Address how corrective action will be accomplished for those having the potential to be affected by the same deficient practice. The administrator and social worker performed an audit of concerns for 30 days prior to the survey and a written response was provided to each concern. This audit was completed on 3/29/17. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. Department heads were in-serviced by the administrator regarding the facilities concern/grievance policy, process and proper procedure for investigating and responding to concerns by March 30, 2017. Indicate how the facility plans to monitor its performance to make sure the	

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F 166	Continued From page 9 be cut. The Investigation dated 01/09/17 noted the resident was notified the podiatrist will be in the facility on 01/24/16 to have his toenails seen. The form stated his name was placed on the list to be seen by the podiatrist. The Resolution section included if the complaint was resolved, if the complainant was satisfied, if the investigation results and resolution were reported to the resident or family and how the resolution was communicated. The resolution section was blank and unsigned. b. On 01/25/17 Resident #5 communicated to Social Worker #1 that he was missing his dentures and reading glasses. The investigation section which was undated stated the Activity Director (AD) talked with Resident #5 about wrapping his dentures up in a paper towel. The AD saw him several times doing this and talked to him about this on several occasions. The trash cans were searched throughout the building and in his room and the dentures were not found. Under results taken, the form stated the AD bought the resident a pair of reading glasses. This section was not signed or dated. The Resolution section included if the complaint was resolved, if the complainant was satisfied, if the investigation results and resolution were reported to the resident or family and how the resolution was communicated. The resolution section was completely blank. Upon follow up interview on 03/01/17 at 10:24 AM, Resident #5 stated that his top denture plate was stolen and he had his bottom denture plate. He stated he placed them in a denture cup and the next morning the top plate was gone. He further stated he had received no response to what the facility was going to do for him regarding his dentures. He did say at this time that his	F 166	solutions are sustained. Administrator or designee will audit concern log weekly for 8 weeks then monthly for 6 months to ensure concerns are being addressed timely and written responses are being provided on concerns. Results of audits will be submitted to the Quality Improvement Committee for review and analysis of patterns and trends.	

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toenails had been trimmed.

Interview with Social Worker (SW) #1 and #2 occurred on 03/01/17 at 5:43 PM. SW # 1 stated that he received a written grievance and it was reviewed by the Administrator then given to the department head responsible for the investigation. SW #2 stated that Resident #5 never liked his new dentures and after 1 week of receiving them the top set were missing. SW #1 stated he did not fill out the resolution as they talked to him and told him where they had looked for the dentures. According to the social workers, the business office was going to look into replacement of the denture but that was not told to Resident #5. Both SWs stated that they had not been giving copies of the complaints, investigation completed or the resolution to the residents in the building as both were unaware of the regulation to do so. SW #1 stated he was the designated staff over the grievance process and was unaware of this regulation.

Interview with the Administrator on 03/01/17 at 6:30 PM revealed he was unaware of the new regulation to ensure complainants were given the written investigation and resolution of any complaints filed with the facility. He stated he was at a corporation meeting this week and learned this.

2. Resident #3 was admitted to the facility on 12/22/16 with diagnoses including heart failure, chronic obstructive pulmonary disease, and hypertension. Her admission Minimum data Set dated 12/29/16 coded her with severely impaired cognition and requiring extensive to total assistance with most activities of daily living skills.

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Resident #3 was discharged to the hospital on 01/02/17 for an evaluation.

Review of the grievance logs revealed Resident #3 had filed 1 Complaint/Grievance Report since December 2016 which was on 01/04/17. This grievance was filed by family verbally relating to 6 gowns missing which had her name in them. In addition the family expressed concern about a sore on her bottom she had when she was admitted to the hospital, bruising on her shoulders, left sitting 5 hours in a wheelchair and having a wet gown on for 3 days.

Under findings of investigation it was noted that one gown was located by housekeeping. The plan to resolve complaint/grievance was that the admission record stated she had a reddened area to her coccyx and bruising to her shoulders bilaterally which were present on admission. Results of actions was that there would be a mandatory staff meeting to discuss resident care. This investigation was signed by the Director of Nursing on 01/17/17. The Resolution section included if the complaint was resolved, if the complainant was satisfied, if the investigation results and resolution were reported to the resident or family and how the resolution was communicated. The resolution section was completely blank.

Interview with the staff responsible for the grievances, Social Worker #1, was completed on 03/01/17 at 5:43 PM. SW #1 stated he was unaware of any requirement to provide written information to complainants regarding the investigation and resolution of grievances filed.

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F 166	Continued From page 12 Interview with the Director of Nursing on 03/01/17 at 6:15 PM revealed she was unaware of the regulation to send the investigation and resolution of any complaints filed to the complainant. She further stated she had tried to call the family several times and never received a return call. Interview with the Administrator on 03/01/17 at 6:30 PM revealed he was unaware of the new regulation to ensure complainants were given the written investigation and resolution of any complaints filed with the facility. He stated he was at a corporation meeting this week and learned this.	F 166		
F 224 SS=D	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph §483.95,	F 224		3/30/17

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F 224	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility neglected to assess a resident's skin with 2 nephrostomy tubes (tubes surgically inserted into kidneys) or provide treatments as ordered by the physician prior to the tubes being dislodged for 1 of 1 resident sampled with nephrostomy tubes (Resident #3). Findings included: Resident #3 was admitted to the facility on 12/22/16 with diagnoses which included heart disease, diabetes, recurrent urinary tract infections and a fistula (opening) between the bladder and colon which required bilateral (2) nephrostomy tubes. Resident #3 was discharged from the facility to the hospital on 01/02/17 after the nephrostomy tubes were dislodged. A review of the admission Minimum Data Set (MDS) dated 12/29/16 revealed Resident #3 was severely impaired in cognition for daily decision making. The MDS further revealed Resident #3 required extensive staff assistance for toileting and hygiene. A review of a nurse's note dated 12/23/16 at 3:15 PM by Nurse #5 indicated external drain from left lower back measured 18 centimeters (cm) in length until blue tubing inserted into a port and on the right lower back she had an external drain that measured 22 cm in length until blue tubing inserted into a port that had 2 sutures intact. A review of physician's orders dated 12/23/16 indicated to clean external drain site on right and left lower back every 3 days with wound cleanser, pat dry and apply dressing with cloth tape.	F 224	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #3 was discharged to the hospital post her nephrostomy tubes coming out. The facility does not believe that resident #3 had any negative outcome post the incident. Address how corrective action will be accomplished for those having the potential to be affected by the same deficient practice. The Director of Nursing educated nursing staff prior to March 30, 2017 to assure understanding of; monitoring and observing any type of surgical drain, reviewing and administering care of drains per the Physician orders, and the documentation of care as related to any surgical drains. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. The Director of Nursing or designee will conduct an audit to be completed on 3/24/17 validating that any resident with a surgical drain has appropriate orders and that the orders are being followed as evidenced on the Treatment Administration Record (TAR).	

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F 224	Continued From page 14 A review of a Treatment Administration Record (TAR) dated 12/23/16 indicated no staff initials that nephrostomy sites on the right or left had been cleaned. A review of a physician's order dated 12/24/16 indicated weekly skin assessments with a complete set of vital signs on Saturday day shift. A review of a TAR dated 12/24/16 indicated vital signs were documented but there was no documentation of Resident #3's skin or assessment of skin around the nephrostomy tubes. A review of a TAR dated 12/29/16 indicated no staff initials that nephrostomy sites on the right or left had been cleaned. A review of a TAR dated 12/31/16 indicated vital signs were documented but there was no documentation of Resident #3's skin or assessment of skin around the nephrostomy tubes. A review of a TAR dated 01/01/17 indicated no staff initials that nephrostomy sites on the right or left had been cleaned. A review of a nurse's note dated 01/02/17 at 10:09 PM by Nurse #7 indicated both nephrostomies were "out of back (entire tubing)" and physician and family were notified. The note further indicated orders were received to send Resident #3 to the hospital. During an interview on 03/01/17 at 5:04 PM with Nurse #10 he stated he recalled Resident #3 had	F 224	Indicate how the facility plans to monitor its performance to make sure the solutions are sustained. The Director of Nursing or designee will conduct an audit of any residents with surgically placed drain tubes to assure that treatments and observations are being documented as per the Physician Orders 3x/week for 4 weeks. Audits will continue with any residents with surgically placed drain tubes 2x/week for 4 weeks then 1x/week for 8 weeks. Results of audits will be referred to the Quality Assurance Committee for review of patterns and trends during the audit period. The QA Committee will continue to evaluate quarterly for 1 year.	

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2 nephrostomies with a stent (a tubular device placed inside an opening to aid healing or relieve an obstruction) from each kidney. He further stated he did not recall doing dressing changes or if he had assessed the skin around the nephrostomy tubes.

During an interview on 03/01/17 at 6:10 PM with Nurse #7 she recalled the nephrostomy tubes leaked some and the twist opening at the bottom of the catheter bags also leaked. She explained any surgical sites were supposed to be assessed for inflammation or infection and she thought Resident #3's nephrostomy tube sites should have been assessed once a shift but she did not recall if she had changed dressings around the nephrostomy tubes or that she had assessed them.

During an interview on 03/02/17 at 8:57 AM with Nurse #6 she stated Resident #3's nephrostomy tube sites should have been assessed every shift and documented but sometimes treatments were not documented when done and sometimes they were not done.

During an interview on 03/02/17 at 11:40 AM with the facility Medical Director he stated it was his expectation for nurses to check the skin around the nephrostomy tube sites every shift to look for redness or drainage or any signs of infection. He further stated he expected for nurses to follow physician's orders and if a treatment was ordered every 3 days it should be done every 3 days. He also stated if there were skin problems he expected for nurses to let him know so they could discuss it.

During an interview on 03/02/17 at 2:38 PM with

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Nurse #5 who was also the Unit Manager she stated she did a skin assessment on Resident #3 on 12/23/16 and realized there were no treatment orders for the nephrostomy tubes so she got the orders to clean external drain sites on left and right lower back every 3 days with wound cleanser, pat dry and apply dressing with cloth tape because Resident #3 had very sensitive skin and was allergic to adhesives. She stated she cleaned around the nephrostomy sites and put dressings around them on 12/23/16 after she got the physician's orders but she guessed she forgot to document it in her notes. She confirmed after review of the treatment sheets that treatments were not documented on 12/29/16 or 01/01/17 when they were scheduled to be done. She stated it was her expectation when treatments were ordered they should be done and it was her expectation for nursing staff to monitor Resident #3's skin around the nephrostomies to ensure there was no redness or drainage or pain around the sites. She explained after review of documentation for Resident #3 she would have liked to have seen how nurses monitored and assessed Resident #3's skin. She confirmed there was no weekly skin assessment documented on 12/24/16 or on 01/31/17 and there were no details about the nephrostomy tubes as far as redness or drainage or if they were intact.

During a telephone interview on 03/02/17 at 3:38 PM with Nurse #9 who was also a charge nurse she did not recall doing any assessments of Resident #3's skin or of the nephrostomy tubes and had not received any reports about skin assessments around the nephrostomy tubes.

During an interview on 03/02/17 at 4:27 PM with

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F 224	Continued From page 17 Nurse #8 she stated she had provided care to Resident #3 on the evening and night shifts from 7:00 PM until 7:00 AM. She stated she did not do any skin assessments or assessments of the nephrostomy tubes and did not recall looking at the skin around the tubes. She further stated dressing changes were done on day shift so she had not done treatments or dressing changes for Resident #3. During an interview on 03/02/16 at 5:03 PM with the Director of Nursing she stated it was her expectation for nursing staff to assess a resident's skin to look for redness, drainage, or for any signs of infection or for anything that looked abnormal. She explained the nephrostomy tube sites should have been assessed because any foreign object in a resident's body should be assessed and documented. She further stated a full head to toe assessment should have been done which included assessments of the nephrostomy tube sites. She stated it was also her expectation for nursing staff to follow physician's orders and treatments and dressing changes should have been done according to the physician's orders.	F 224		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	F 226		3/30/17

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F 226	Continued From page 18 (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to follow their abuse policy and procedure to investigate an injury and file a 24 hour and 5 working day report to the North Carolina Health Care Personnel Investigations (state agency) for 1 of 1 resident sampled for abuse (Resident #4). Findings included: A review of a facility policy and procedure titled Abuse and Neglect Protocol with a revised date of April 2010 indicated in part a policy statement that it was the responsibility of employees to	F 226	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #4 left the facility against medical advice on December 2, 2016. The facility is not aware of any negative outcomes to the resident from this incident. Address how corrective action will be accomplished for those having the potential to be affected by the same	

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F 226	Continued From page 19 promptly report any incident or suspected incident of resident abuse to facility management. A section labeled "Provision of documentation to Administrator" indicated in part, a completed copy of documentation forms and written statements from witnesses, if any, must be provided to the Administrator immediately after the occurrence of an incident of suspected abuse and facility must immediately report to designated state agency. An immediate investigation will be made and a copy of the findings of such investigation will be provided to the state agency within 5 working days or as designated by state law. A section titled "Investigation Process" indicated in part to interview other residents to whom the accused employee provides care or services. Resident #4 was admitted to the facility on 11/11/16 with diagnoses which included muscle weakness, iron deficiency anemia, pain, depression and anxiety. A review of the admission Minimum Data Set (MDS) dated 11/18/16 indicated Resident #4 was moderately impaired in cognition for daily decision making. The MDS also indicated Resident #4 required extensive assistance for bed mobility, transfers and toileting. A review of 24 hour and 5 working day reports revealed there were no reports to the state agency for Resident #4. A review of a nurse's note dated 11/28/16 at 9:53 AM by Nurse #5 indicated she was called to Resident #4's room by admissions staff because Resident #4 complained of left elbow pain. The note revealed Resident #4 had a raised area that was tender to touch and was not soft and Resident #4 stated that it happened during a	F 226	deficient practice. No other allegations of abuse have been reported since this incident occurred. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. The administrator or designee in-serviced staff regarding the facilities abuse and neglect policy prior to March 30, 2017. Indicate how the facility plans to monitor its performance to make sure the solutions are sustained. The administrator or designee will interview five (5) randomly selected staff members 5x/weekly for four (4) weeks regarding knowledge of the abuse and neglect policy. Interviews will then take place with four (4) randomly selected staff members 3x/week for four (4) weeks. Then interviews will be performed with five (5) staff members weekly for 8 weeks. Results of audits will be submitted to the Quality Assurance Committee for review and recommendations. The QA committee will perform random audits quarterly for one year to determine ongoing understanding of the abuse and neglect policy.	

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transfer 2-3 days ago. The notes further revealed there was also a blue bruise that measured 2.5 centimeters (cm) by 0.3 cm on inner left antecubital site (region of the arm in front of the elbow) and a new order was received for an x-ray of left elbow.

A review of an incident report dated 11/28/16 with a revised date at 2:04 PM indicated Nurse #5 was called to Resident #4's room by admissions staff that Resident #4 was complaining of pain in his left elbow. The report revealed Nurse #5 assessed Resident #4 and noted a raised area that was tender to touch and was not soft and there was a blue bruise that measured 2.5 cm by 0.3 cm on the inner left antecubital site. The report further revealed Resident #4 denied having blood drawn from this site and stated it had happened during a transfer.

A review of a mobile x-ray report dated 11/28/16 of Resident #4's left elbow revealed a radial head fracture and suspicious for acute fracture.

A review of a document completed by the former Director of Nursing (DON) dated 11/29/16 who no longer worked at the facility indicated Resident #4 complained of left arm pain and when a nurse examined his arm she noted a bruise in the shape of a thin line right beside a hematoma (a solid swelling of clotted blood within the tissues) on his inner arm. The document revealed Resident #4 described a female who had helped him stand up from the bed and was holding him under his arm and on the back of his pants and said she was real quick about it. The document indicated because Resident #4 complained of pain the physician was notified and ordered an x-ray. The document further indicated family was

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at Resident #4's bedside and requested to speak to staff about their investigation. The document revealed the DON asked Resident #4 to tell her what happened again and Resident #4 stated a "trainee" was going to help him up out of his wheelchair and grabbed his left arm and used both of her arms and pulled him out of the wheelchair. The document further revealed she asked Resident #4 if the staff member was mean and he said "no, just fast" and then asked him if the staff member was in a hurry and he said "yes, now you've got it." The document revealed 2 Nurse Aides (NAs) were identified who somewhat matched the description by Resident #4 and were interviewed. The document further revealed Nurse Aide (NA) #3 had been assigned to care for Resident #4 on second shift from 3:00 PM - 11:00 PM on Thursday 11/24/16 and NA #4 worked a section of the hall where Resident #4 lived on Friday 11/25/16 but was not assigned to his care. The document revealed these were the only 2 Nurse Aides (NAs) interviewed during the investigation. The document further indicated NA #3 stated Resident #4 had called for assistance and was sitting on the side of his bed and stood up unassisted and she helped him to pull up his pants. The document further revealed the former DON requested to send Resident #4 to the hospital to get another x-ray since mobile x-rays were sometimes inaccurate and the description of the incident by Resident #4 and NA's did not seem to line up with the type of injury he sustained.

A review of a hospital x-ray report dated 11/29/17 of Resident #4's left elbow revealed no acute fracture or dislocation.

A review of a progress note dated 11/30/16 by a

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Nurse Practitioner indicated she saw Resident #4 for an injury to his left elbow. The note revealed Resident #4 reported the injury had occurred last Thursday 11/24/16 or Friday 11/25/16 and there was extensive bruising and swelling to the medial (middle) left elbow and Resident #4 stated injuries were sustained when trying to transfer from a wheelchair. The note further revealed extensive bruising extended from the proximal (toward the center) of his left upper extremity down to the elbow with green tinted bruising proximal to elbow and darker blue/black bruising to medial antecubital space.

A review of a nurse's note dated 12/01/16 at 10:18 AM by Nurse #6 revealed Resident #4 continued bruising of various stages to his left elbow and upper arm and Resident #4 stated an orderly had picked him up by his left arm from his wheelchair and had caused bruising about two weeks ago but he had also made previous statements that it happened last Thursday 11/24/16 or last Friday 11/25/17 and would continue to monitor.

A review of a physician's progress note dated 12/01/16 indicated Resident #4 had developed a hematoma on the medial aspect of his left elbow. The note further indicated recently while Resident #4 was assisted by the staff to stand from a wheelchair he developed a left elbow injury and x-rays were obtained and showed a possible radial fracture. The note revealed the x-rays were repeated at the hospital and did not show any evidence of bone injury but he had developed a large hematoma in the area that was now tender to palpation. The note further revealed Resident #4 had extensive bruising from the proximal left upper extremity down to the elbow

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with hematoma and some pain to mobilization of left elbow but range of motion was normal.

During an interview on 03/01/17 at 2:55 PM, Nurse #5 stated she recalled Resident #4 had a bruise on left elbow. She explained she thought he might have hit his arm on the armrest of the wheelchair but she was not exactly sure how it had happened.

During an interview on 03/02/17 at 3:50 PM, NA #3 confirmed she provided care to Resident #4 on Thursday 11/24/16 and she fed him and later she changed him and he wanted to get up out of bed. She explained he was struggling to get up from the bed so she helped him stand and she had her hands around his waist and assisted him to walk in the room. She stated she did not pull on his arms to help him up and was not in a hurry while she provide care for him.

During an interview on 03/02/17 at 4:04 PM, NA #4 confirmed she was called in for an investigation of Resident #4's injury but she was not assigned to care for him. She stated she did not know how Resident #4 had injured his arm because she did not know a lot about Resident #4.

During an interview on 03/02/17 at 1:05 PM, the Administrator confirmed facility staff did not submit 24 hour or 5 working day reports for the bruise and hematoma on Resident #4's left elbow. He explained he had talked to Resident #4 and he said a NA had pulled him up quick when she had assisted him. He confirmed there was no documentation of interviews with other residents who received care from NAs who were assigned to Resident #4 to ensure their safety

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F 226	Continued From page 24 because at the time he did not think abuse had occurred. He stated after review of the investigation and policy and procedure he would have expected for interviews to be done with residents and should have been done as part of their investigation.	F 226		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 279		3/30/17

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F 279	Continued From page 25 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to develop a comprehensive care plan that included measurable goals and approaches for 1 of 1 resident sampled with nephrostomy tubes (Resident #3). Findings included: Resident #3 was admitted to the facility on	F 279	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #3 was discharged post event of her nephrostomy tubes coming out. The facility does not believe that resident #3 had a negative outcome as a result of that	

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F 279	Continued From page 26 12/22/16 with diagnoses which included heart disease, diabetes, recurrent urinary tract infections and a fistula (opening) between the bladder and colon which required bilateral (2) nephrostomy tubes. Resident #3 was discharged from the facility to the hospital on 01/02/17 after the nephrostomy tubes were dislodged. A review of the admission Minimum Data Set (MDS) dated 12/29/16 revealed Resident #3 was severely impaired in cognition for daily decision making. The MDS further revealed Resident #3 required extensive staff assistance for toileting and hygiene. A review of a facility document titled Resident Interim Care Plans dated 12/23/16 revealed a hand written note "Urostomy's x 2 - one on left and right lower back." A section labeled goals was blank and a section labeled approaches was blank. During an interview on 03/02/17 at 2:38 PM, Nurse #5 who was also the Unit Manager verified she had documented on the interim care plan after Resident #3 was admitted. She explained the interim care plan documents were part of the admission packet and they were supposed to be the beginning of a care plan. She stated she had not been told how to fill them out but it was her understanding to document the problem and need to the best of her ability and then MDS staff would generate the official care plan. She confirmed there were no goals or interventions listed on the care plan and was therefore not useful for staff in regard to care provided to Resident #3. During an interview on 03/02/17 at 5:03 PM with the Director of Nursing she confirmed the interim	F 279	occurrence. Address how corrective action will be accomplished for those having the potential to be affected by the same deficient practice. The Director of Nursing upon identifying that Interim Care plans were not completed accurately and with understanding from the Charge Nurses, provided an in-service to nurses on or prior to 3/30/17 on the purpose of the Interim Care Plan and how to accurately fill out according to acute conditions of the admitted resident. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. The Director of Nursing and Unit managers completed an audit of new admission from 3/2/17 to 3/17/17 to assure that Interim Care plans were in place and accurately reflecting the residents' conditions. Indicate how the facility plans to monitor its performance to make sure the solutions are sustained. The Director of Nursing or designee will audit 100% of the next thirty (30) days of admissions to assure that Interim Care Plans have been completed accurately. The audits will then be completed 3x/week for 4 weeks on new admits that	

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F 279	Continued From page 27 care plan for Resident #3 did not include goals or approaches for staff to provide care for the nephrostomy tubes. She stated it was her expectation for nursing staff to document on the interim care plan anything that required care and the care plan should include goals and be individualized to the resident's needs. She stated she would have expected to see more specific information related to the nephrostomy tubes documented on Resident #3's interim care plan.	F 279	day to validate that the Interim Care Plan is in place and accurate. Audits will continue 1x/week for 8 weeks. Results of audits will be submitted to the Quality Assurance Committee for review and further recommendations. The QA committee will continue to monitor on a quarterly basis to determine if additional issues arise.	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice,	F 309		3/30/17

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F 309	Continued From page 28 the comprehensive person-centered care plan, and the residents' goals and preferences. (I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to assess 2 nephrostomy tubes (tubes surgically inserted into kidneys) on a resident's back or assess skin around the nephrostomy tube sites and failed to provide treatments as ordered by the physician prior to the tubes being dislodged (Resident #3). Findings included: Resident #3 was admitted to the facility on 12/22/16 with diagnoses which included heart disease, diabetes, recurrent urinary tract infections and a fistula (opening) between the bladder and colon which required bilateral (2) nephrostomy tubes. Resident #3 was discharged from the facility to the hospital on 01/02/17 after the nephrostomy tubes were dislodged. A review of the admission Minimum Data Set (MDS) dated 12/29/16 revealed Resident #3 was severely impaired in cognition for daily decision making. The MDS further revealed Resident #3 required extensive staff assistance for toileting and hygiene. A review of a nurse's note dated 12/23/16 at 3:15 PM by Nurse #5 indicated external drain from left lower back measured 18 centimeters (cm) in	F 309	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #3 was discharged to the hospital post her nephrostomy tubes coming out. The facility does not believe resident #3 had any negative outcome post the incident. Address how corrective action will be accomplished for those having the potential to be affected by the same deficient practice. On or prior to 3/30/17, the Director of Nursing educated the nurses to assure understanding of; monitoring and observing any type of surgical drain, reviewing and administering care of drains per the Physician orders, and the documentation of care as related to any surgical drains. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not	

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F 309	Continued From page 29 length until blue tubing inserted into a port and on the right lower back she had an external drain that measured 22 cm in length until blue tubing inserted into a port that had 2 sutures intact. The note further indicated both nephrostomy drains were draining yellow color urine in each bag. A review of a physician's order dated 12/23/16 indicated to clean external drain site on right lower back every 3 days with wound cleanser, pat dry and apply dressing with cloth tape. A review of a physician's order dated 12/23/16 indicated to clean external drain site on left lower back every 3 days with wound cleanser, pat dry and apply dressing with cloth tape. A review of a Treatment Administration Record (TAR) dated 12/23/16 indicated no staff initials that nephrostomy sites on the right or left had been cleaned. A review of an Interim Care Plan dated 12/23/16 indicated 2 nephrostomies with 1 on the left and 1 on the right lower back but there were no goals or approaches listed. A review of a physician's order dated 12/24/16 indicated weekly skin assessments with a complete set of vital signs on Saturday day shift. A review of a TAR dated 12/24/16 indicated vital signs were documented but there was no documentation of Resident #3's skin or assessment of skin around the nephrostomy tubes. A review of a physician's progress note dated 12/29/16 by the former Medical Director indicated	F 309	occur. The Director of Nursing or designee will conduct an audit to be completed on 3/24/17 validating that any resident with a surgical drain has appropriate orders and that the orders are being followed as evidenced on the Treatment Administration Record (TAR). Indicate how the facility plans to monitor its performance to make sure the solutions are sustained. The Director of Nursing or designee will conduct an audit of any residents with surgically placed drain tubes to assure that treatments and observations are being documented as per the Physician Orders 3x/week for 4 weeks. Audits will continue with any residents with surgically placed drain tubes 2x/week for 4 weeks then 1x/week for 8 weeks. Results of audits will be referred to the Quality Assurance Committee for review of patterns and trends during the audit period. The QA Committee will continue to evaluate quarterly for 1 year.	

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Resident #3 had bilateral nephrostomy sites but was still able to urinate.

A review of a TAR dated 12/29/16 indicated no staff initials that nephrostomy sites on the right or left had been cleaned.

A review of a TAR dated 12/31/16 indicated vital signs were documented but there was no documentation of Resident #3's skin or assessment of skin around the nephrostomy tubes.

A review of a TAR dated 01/01/17 indicated no staff initials that nephrostomy sites on the right or left had been cleaned.

A review of a nurse's note dated 01/02/17 at 10:09 PM by Nurse #7 indicated both nephrostomies were "out of back (entire tubing)" and physician and family were notified. The note further indicated orders were received to send Resident #3 to the hospital.

During an interview on 02/28/17 at 5:47 PM with Nurse Aide (NA) #1 she recalled she provided care for Resident #3 because the resident had 2 "wires" in her lower back into her kidneys. She stated Resident #3 wore a special belt that was wide and kept the tubes in place and she had never seen anything like that before. She explained it looked like there was a wire in the skin on the right and left sides of her lower back that were attached to small tubes and the tubes had 2 small slender catheter bags attached to them. She stated she emptied urine out of the catheter bags and Resident #3 was also incontinent of urine from her bladder. She further explained she did not recall seeing any dressings

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or stitches around the tubes. She stated one night she turned and changed Resident #3 and noticed the wire was not connected to her back on the right side and she did not think the one on the left side looked like it was connected. She stated she called Nurse #8 to the room and the nurse said she was going to call Emergency Medical Services and Resident #3 was sent out to the hospital.

During an interview on 03/01/17 at 5:04 PM with Nurse #10 he stated he recalled Resident #3 had 2 nephrostomies with a stent (a tubular device placed inside an opening to aid healing or relieve an obstruction) from each kidney. He explained she wore a special belt that the tubes looped through and the drainage bags hung down in the front on her thighs. He stated he did not recall if there were dressings around the nephrostomy sites and did not recall doing dressing changes or if he had assessed the skin around them.

During a telephone interview on 03/01/17 at 4:01 PM with NA #5 she stated she had provided care for Resident #3 and remembered the catheters in her back and the catheter bags screwed open at the bottom to empty them. She explained when Resident #3 was first admitted she had gauze around the catheters that was split and fit around the tubes but then she couldn't recall seeing them after that. She stated they had to change Resident #3's bed 3-4 times a shift because she was incontinent and she usually had to empty the nephrostomy bags twice a shift.

During an interview on 03/01/17 at 6:10 PM with Nurse #7 she explained Resident #3 knew how to keep the nephrostomy tubes in the special belt she wore. She stated she recalled the

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nephrostomy tubes leaked some and the twist opening at the bottom of the catheter bags also leaked. She explained any surgical sites were supposed to be assessed for inflammation or infection and she thought Resident #3's nephrostomy tube sites should have been assessed once a shift and documented. She further stated she would have thought when the dressings were changed around the nephrostomy tubes there should have been an assessment but she did not recall she changed dressings around the nephrostomy tubes or that she had assessed them.

During an interview on 03/02/17 at 8:57 AM with Nurse #6 she stated she completed Resident #3's admission assessment. She explained she had received report before Resident #3 was admitted that she had nephrostomy tubes inserted into her kidneys to drain urine. She stated she did not recall any treatment orders for Resident #3. She stated Resident #3 wore a special belt to hold the nephrostomy tubes in place and her nephrostomy tube sites should have been assessed every shift and documented but sometimes treatments were not documented when done and sometimes they were not done. She explained after review of documentation in Resident #3's medical record, there were sections in the notes that pertained to wound treatments but there was nothing specific regarding assessment of the incision sites. She confirmed the weekly skin assessment should have included more documentation about the nephrostomy tube sites but the computer system only allowed a limited number of characters and they could not do lengthy notes. She stated there should have been some handwritten notes for a full skin assessment and documentation about the nephrostomy tubes and the condition of her

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skin around the tubes.

During an interview on 03/02/17 at 11:40 AM with the facility Medical Director he confirmed he had only been the Medical Director in the facility since January 2017. He stated he vaguely recalled Resident #3 but remembered hearing that a nephrostomy tube came out and she was sent out to the hospital. He explained nephrostomy tubes came out fairly easily and when that happened the resident would have to be sent to the hospital for further evaluation and treatment. He stated it was his expectation for nurses to check the skin around the nephrostomy tube sites every shift to look for redness or drainage or any signs of infection. He further stated he expected for nurses to follow physician's orders and if a treatment was ordered every 3 days it should be done every 3 days. He also stated if there were skin problems he expected for nurses to let him know so they could discuss it.

During an interview on 03/02/17 at 2:38 PM with Nurse #5 who was also the Unit Manager she stated she did a skin assessment on Resident #3 on 12/23/16 and the right nephrostomy tube was sutured in place but the left nephrostomy tube did not have sutures. She explained she realized there were no treatment orders for the nephrostomy tubes so she got the orders to clean external drain sites on left and right lower back every 3 days with wound cleanser, pat dry and apply dressing with cloth tape because Resident #3 had very sensitive skin and was allergic to adhesives. She stated she cleaned around the nephrostomy sites and put dressings around them on 12/23/16 after she got the physician's orders but she guessed she forgot to document it in her notes. She confirmed after review of the

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treatment sheets that treatments were not documented on 12/29/16 or 01/01/17 when they were scheduled to be done. She stated it was her expectation when treatments were ordered they should be done and it was her expectation for nursing staff to monitor Resident #3's skin around the nephrostomies to ensure there was no redness or drainage or pain around the sites. She explained after review of documentation for Resident #3 she would have liked to have seen how nurses monitored and assessed Resident #3's skin and that the nephrostomy tubes were draining urine and the color of the urine. She verified there were no skin assessments or notes regarding the nephrostomy tubes in the nursing summaries. She confirmed there was no weekly skin assessment documented on 12/24/16 or on 01/31/17 and there were no details about the nephrostomy tubes as far as redness or drainage or if they were intact.

During a telephone interview on 03/02/17 at 3:38 PM with Nurse #9 who was also a charge nurse she stated Nurse #8 called her to Resident #3's room when the nephrostomy tubes came out. She stated she called the on-call physician and sent Resident #3 out to the hospital. She further stated she did not recall doing any assessments of Resident #3's skin or of the nephrostomy tubes and had not received any reports about skin assessments around the nephrostomy tubes.

During an interview on 03/02/17 at 4:27 PM with Nurse #8 she stated she had provided care to Resident #3 on the evening and night shifts from 7:00 PM until 7:00 AM. She stated she did not do any skin assessments or assessments of the nephrostomy tubes. She further stated she did not recall looking at the skin around the tubes.

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She explained she was assigned to care for Resident #3 the night the tube came out and was making rounds around 9:30 PM or 10:00 PM when NA #1 called her to Resident #3's room and stated she needed to look at Resident #3's tubes because something was wrong. She stated there was a dressing that was partially on and partially off on the right side and laying in the bed beside it was the nephrostomy tube coiled up with the sutures around the tube. She further stated on the left side the tube was pulled out but was still partially in the skin. She stated the charge nurse called the physician on call and got an order to send Resident #3 out to hospital. She stated dressing changes were done on day shift so she had not done them and she had not done any skin assessments or assessed the nephrostomy tubes before that night.

During an interview on 03/02/16 at 5:03 PM with the Director of Nursing she stated it was her expectation for nursing staff to assess a resident's skin to look for redness, drainage, or for any signs of infection or for anything that looked abnormal. She explained the nephrostomy tube sites should have been indicated in the computer documentation as wounds since they had surgical incisions and staff should have documented assessments of them. She further explained any foreign object in a resident's body should be assessed and documented and a full head to toe assessment should have been done which included assessments of the nephrostomy tube sites. She stated it was also her expectation for nursing staff to follow physician's orders and treatments and dressing changes should have been done according to the physician's orders.

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F 514	Continued From page 36	F 514		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the	F 514	Address how corrective action will be	3/30/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 37 facility failed to accurately document skin assessments related to pressure sores on a resident's heels for 1 of 3 residents sampled for pressure sores (Resident #9). Findings included: Resident #9 was admitted to the facility on 11/19/16 with diagnoses which included vitamin deficiency, kidney failure, anemia, depression and a pressure ulcer to her right heel. A review of the most recent quarterly Minimum Data Set (MDS) dated 02/08/17 revealed Resident #9 was cognitively intact for daily decision making. The MDS further indicated Resident #9 was totally dependent on staff for transfers, hygiene and bathing. A review of monthly physician's orders dated 02/01/17 through 02/28/17 revealed in part to cleanse wound on right heel and apply Multidex powder (a wound filler to promote wound healing) to wound bed; apply Triad (wound cream) to periwound; cover with absorbent dressing and apply gauze wrap and tape daily. The orders also indicated a stage 1 pressure ulcer on left heel and to apply skin prep daily. A review of a care plan dated 02/14/17 with a problem statement of actual wound to right heel indicated goals that wound would show signs of healing and remain free from infection. The interventions were listed in part for a pressure relieving/reducing device to bed and in wheelchair; administer treament's as ordered and monitor for effectiveness; assess, record and monitor wound healing; measure length, width and depth where possible; assess and document status of wound perimeter, wound bed and	F 514	accomplished for those residents found to have been affected by the deficient practice. The facility conducted a head to toe assessment of resident #9 on 3/22/174. No new or worsened areas were identified as a result of that skin assessment. Address how corrective action will be accomplished for those having the potential to be affected by the same deficient practice. The Director of Nursing or designee performed an audit of skin assessments for all residents in the building on 3/17/17. Skin assessments were up to date on all residents in the building. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. The Director of Nursing or designee will perform audits of skin assessments 1x/week for four (4) weeks, then 2x/month for three (3) months, then 1x/month for three (3) months to ensure skin assessments are being performed routinely. Indicate how the facility plans to monitor its performance to make sure the solutions are sustained. Results of audits will be submitted to the Quality Assurance Committee for review	

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F 514	Continued From page 38	F 514		

healing progress; report improvements and declines to physician; assist to turn and reposition at least every 2 hours, or as needed or requested; monitor nutritional status; monitor, document and report any changes in skin status and observe dressing daily to ensure it is intact and adhering.

A review of a weekly skin assessment dated 01/08/17 indicated in a section labeled additional comments treatment continues to right heel as ordered but there was no documentation regarding the left heel.

A review of a weekly skin assessment dated 01/15/17 indicated in part in a section labeled additional comments treatment continues to right heel as ordered but there was no documentation regarding the left heel.

A review of a weekly skin assessment dated 01/25/17 indicated in part in a section labeled additional comments treatment continues to left heel as ordered but there was no documentation regarding the right heel.

A review of a weekly skin assessment dated 02/01/17 indicated in part in a section labeled additional comments treatment continues to right heel as ordered but there was no documentation regarding the left heel.

A review of a weekly skin assessment dated 02/08/17 indicated in part in a section labeled additional comments treatment continues to left heel as ordered but there was no documentation regarding the right heel.

A review of a weekly skin assessment dated

and recommendations. The QA Committee will continue to monitor quarterly for 1 year and will address any issues that arise.

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F 514	Continued From page 39	F 514		

02/15/17 indicated in part in a section labeled additional comments treatment continues to right heel as ordered but there was no documentation regarding the left heel.

A review of a weekly skin assessment dated 02/22/17 indicated in part in a section labeled additional comments treatment continues to left heels as ordered but there was no documentation regarding the right heel.

During an interview on 03/02/17 at 1:41 PM with Nurse #3 she explained she had been the treatment nurse in the facility in the past but recently had changed positions as a Unit Coordinator. She stated nurses on each hall were supposed to do skin assessments once a week. She explained the expectations was for the weekly skin assessments to be completed on a resident's shower day because it was easier to do a full head to toe assessment at that time. She further explained they had changed computer programs and the documentation was problematic because the system was limited to the number of characters they could type in a box on the weekly skin assessments and that prevented them from doing narrative notes. She stated it was now more difficult for nurses to document their assessments. She confirmed Resident #9 had a stage 3 pressure sore on her right heel and staff were putting skin prep on her left heel as a preventive measure. After review of the weekly skin assessments she confirmed the documentation was incomplete and inaccurate. She stated assessments should be accurately documented and nursing assessments needed improvement.

During an interview on 03/02/17 at 5:03 PM with

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F 514	Continued From page 40 the Director of Nursing she stated she felt there was a need for additional nursing education regarding documentation. She stated it was her expectation that the weekly skin assessments should be a full head to toe assessment and it should be documented completely and accurately.	F 514		