

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/03/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345249	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2017
NAME OF PROVIDER OR SUPPLIER MOREHEAD NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 205 EAST KINGS HIGHWAY EDEN, NC 27288		
(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 278 SS=D	<p>483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.</p> <p>(h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>(i) Certification (1) A registered nurse must sign and certify that the assessment is completed.</p> <p>(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>(j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-</p> <p>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or</p> <p>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.</p> <p>(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum</p>	F 278	1. The Minimum Data Set assessment for Resident #93 was corrected to reflect	9/21/17	

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

TITLE

(X6) DATE

Electronically Signed

09/12/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 278	<p>Continued From page 1</p> <p>Data Set (MDS) assessment to reflect the hospice care and indwelling urinary catheter for 1 of 12 sampled residents (Resident #93), reviewed for MDS assessment.</p> <p>Findings Included:</p> <p>Resident# 93 was admitted on 3/29/17 with diagnoses included moderate degree malnutrition, chronic obstructive pulmonary disease, diabetes mellitus, urinary tract infection and neurogenic bladder with urinary retention.</p> <p>1. Review of Minimum Data Set (MDS) assessment for significant changes, dated 6/13/17, revealed that Resident 93 ' s cognition was severely impaired, and she was not coded for hospice services.</p> <p>Review of Resident 93 ' s plan of care, dated on 6/2/17, revealed that the resident had significant changes in condition and received hospice service.</p> <p>Review of Resident 93 ' s hospice comprehensive assessment and care plan, dated 6/1/17, indicated that based on the diagnoses and disease progress, resident ' s prognosis was six months or less, and she was recommended to start the hospice program.</p> <p>Record review of the multiple nurses ' notes for June - August 2017 revealed that Resident #93 received hospice service, provided by hospice team from 6/1/17 three times a week, according to hospice plan of care.</p> <p>Record review of the hospice progress notes for June - August 2017 revealed that hospice aides came three times a week and hospice nurse</p>	F 278	<p>the hospice care and indwelling urinary catheter.</p> <p>2. A audit on all residents receiving hospice care and that have a indwelling urinary catheter to ensure their Minimum Data Set assessment is current and accurate. The audit will be completed by MDS Coordinator and/or designee.</p> <p>3. A monthly audit will be completed on all residents receiving hospice care and that have an indwelling urinary catheter will have their Minimum Data Set assessment checked to ensure accuracy. The audit will be completed by MDS Coordinator and/or designee.</p> <p>4. The results of the monthly audit will be reviewed as part of our Monthly Quality Assessment and Assurance Committee to ensure the Minimum Data Set assessments for hospice care residents with indwelling urinary catheter are current and accurate. Any deficient practice will be problem solved by the QA Committee, with implementation to be handled by MDS Coordinator and/or designee.</p>		

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F 278	<p>Continued From page 2</p> <p>came weekly to provided hospice care for Resident #93.</p> <p>On 8/23/17 at 10:40 AM, during an interview, Nurse Aide #1 indicated that Resident #93 received hospice program. The hospice aides came to the facility three times a week to provide morning and comfort care. The hospice nurse came weekly. The facility ' s nurse aides communicated with hospice team to provide the care.</p> <p>On 8/23/17 at 10:50 AM, during an interview, Nurse #1 indicated that Resident #93 received hospice program from the beginning of June 2017. The hospice aides came three times a week and the hospice nurse came weekly or more often to coordinate the care. The aides communicated with hospice nurse and floor nurse in regards to resident ' s care.</p> <p>On 8/23/17 at 10:55 AM, during an interview, Hospice Nurse, indicated that Resident #93 began hospice program on 6/1/17. Hospice Nurse came to Resident #93 weekly to provide care, according to care plan. The hospice team coordinated hospice plan of care with nursing care plan weekly.</p> <p>On 8/23/17 at 11:15 AM, during an interview, MDS Nurse #1 indicated that she was notified about hospice program for Resident #93 on 6/1/17. Another MDS nurse, who was responsible for significant change MDS assessment, did not complete hospice section on 6/13/17 MDS assessment, which was an error.</p> <p>On 8/23/17 at 21:25 AM, during an interview, Director of Nursing , indicated that she expected</p>	F 278			

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F 278	<p>Continued From page 3</p> <p>the MDS nurses to complete the assessments accurately and on time.</p> <p>2. Review of Minimum Data Set (MDS) assessment for significant changes, dated 6/13/17, reveled that Resident 93 ' s cognition was severely impaired, and she was not coded for indwelling urinary catheter.</p> <p>Record review revealed the initial physician ' s order, dated 5/28/17, for Resident #93 ' to use Foley (indwelling urinary catheter) catheter due to urinary retention.</p> <p>Record review of the care tracker for Resident #93 revealed that from 6/7/17 to 6/13/17 the resident received catheter care, provided by the nurse aides daily.</p> <p>On 8/23/17 at 10:35 AM, Resident #93 was observed in bed with Foley catheter in place, connected to the covered drainage bag.</p> <p>On 8/23/17 at 10:40 AM, during an interview, Nurse Aide #1 indicated that it was her responsibility to provide catheter care for Resident #93 and empty the urinary drainage bag during the shift.</p> <p>On 8/23/17 at 11:15 AM, during an interview, Nurse #2 indicated that Resident #93 had indwelling urinary catheter for two-three months, including the period from 6/7/17 to 6/13/17.</p> <p>On 8/23/17 at 11:15 AM, during an interview, MDS Nurse #1 indicated that she observes residents seven days prior to complete MDS assessment for urinary catheter. Another MDS nurse, who was responsible for the assessment</p>	F 278			

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F 278	Continued From page 4 of Resident #93, marked he was always urinary incontinent with indwelling catheter section not coded, which was an error. On 8/23/17 at 21:25 AM, during an interview, Director of Nursing, indicated that indwelling urinary catheter MDS section should reflect the actual situation with Foley catheter for seven previous days.	F 278			
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to monitor the development and treatment of pressure ulcers for one of one residents reviewed for pressure ulcers (Resident #139). Findings included:	F 314	1. Resident #139's pressure ulcer treatment was reviewed and updated accordingly to address the resident's current pressure ulcer status and making use of the facility's pressure ulcer protocols.	9/21/17	

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F 314	<p>Continued From page 5</p> <p>Resident #139 was admitted 07/01/16 with diagnoses that included unspecified dementia, restlessness and agitation, and anxiety disorder.</p> <p>The most recent Minimum Data Set (MDS) dated 08/01/17 was completed for a significant change in resident ' s condition (a new medical diagnosis of failure to thrive). The MDS indicated that the resident had severe cognitive impairment and was totally dependent for all activities of daily living. The following pressure ulcers were documented: one Stage 2, one unstageable area, and three unstageable deep tissue injuries. No skin integrity issues were recorded on the previous MDS, a quarterly review dated 05/30/17.</p> <p>The care plan for Resident #139 updated 08/22/17 listed measures to address pressure ulcer development such as repositioning the resident, placing "bunny boots" while in bed, applying skin prep to heels twice a day, and using a pressure-relieving mattress and chair cushion.</p> <p>A nursing progress note dated 06/23/17 documented the discovery of and initial assessment and measurement of two Stage 2 wounds to the sacrum and left buttocks.</p> <p>A medical order to initiate the "Stage 2 protocol to sacrum and left buttocks" for Resident #139 was dated 06/23/17 and signed by the physician on 07/02/17. The Stage 2 protocol directed nurses to "measure (in centimeters) the area weekly. Note wound bed tissue appearance, amount/type of drainage and peri-wound details ...skin condition every shift."</p> <p>No measurements or descriptions of wound</p>	F 314	<p>2. An audit was completed on all current residents <input type="checkbox"/> with facility acquired pressure areas to ensure facility pressure ulcer protocols were being followed appropriately. The audit will be completed by the Director of Nursing and/or designee.</p> <p>3. All RN/LPN staff will be in-serviced on the use of the facility <input type="checkbox"/>s pressure ulcer protocols. The Clinical Nurse Manager and/or designee will conduct the RN/LPN staff in-service. Clinical Nurse Manager and/or designee will monitor for staff compliance through weekly audits of charts of residents with facility acquired pressure areas.</p> <p>4. All weekly audit results will be reviewed and discussed in the facility <input type="checkbox"/>s Quality Assurance Meeting quarterly. Any findings for process improvement will be communicated back to direct care staff by the Clinical Nurse Manager and/or designee.</p>	

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F 314	<p>Continued From page 6</p> <p>status were present on the Pressure Ulcer Assessment sheets labeled with Resident #139 's name.</p> <p>A review of nursing progress notes revealed two notes after the initial assessment on 06/23/17 that included measurements and/or descriptions of the wound beds, one dated 08/01/17 and one dated 08/08/17.</p> <p>The 08/01/17 nursing progress note documented the sacral wound as now unstageable and the presence of a new Stage 2 wound to the right buttocks. The 08/08/17 nursing progress note recorded the merging of the right buttock wound with the sacral wound.</p> <p>Measurements were present in the medical record progress notes for the following pressure ulcers:</p> <p>1) Sacral - 06/23/17 initial assessment: 2.0 centimeters (cm) x 0.5 cm, 08/01/17 measurement of 1.5 cm x 2.3 cm x 0.1 cm, 08/08/17 measurement of 4.0 cm x 6.5 cm x 1.0 cm.</p> <p>2) Left buttock - 06/23/17 initial assessment: 1.0 cm x 1.0 cm, 08/08/17 measurement of 1.0 cm x 1.0 cm.</p> <p>3) Right buttock - 08/01/17 initial assessment 1.0 cm x 1.0 cm.</p> <p>The nursing progress note dated 08/08/17 recorded the presence of purulent drainage with a foul odor. A wound culture was performed for Resident #139 and she was subsequently treated with an oral antibiotic.</p> <p>A physician order dated 08/14/17 and signed by</p>	F 314			

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F 314	<p>Continued From page 7</p> <p>the physician on 08/20/17 read "cleanse unstageable to sacrum with antibacterial wound cleanser. Pat dry. Apply Maxorb Extra AG+. Cover with Optifoam. Change dressing only when dressing becomes saturated with drainage. Dressing may be left in place up to 7 days."</p> <p>The wound dressing for Resident #139 was observed on 08/24/17 at 4:33 p.m. Nurse #4 lifted the sacral dressing on the corner so the wound could be examined. A large ulcerated area on the sacrum with depth was present. Measurements were not taken. Nurse #4 acknowledged that the sacral dressing currently applied (dated and initialed 08/22/17) was saturated and needed replacement.</p> <p>In an interview on 08/24/17 at 10:59 a.m., Clinical Nurse Manager #1 confirmed that two measurements of the sacral area (dated 08/01/17 and 08/08/17) had been taken in the nine weeks following the discovery and initial assessment of the skin breakdown on 06/23/17. Documentation of wound status was missing for seven weeks. She indicated that residents' wound progression was monitored through the weekly "weight and wound meeting" attended by the two clinical nurse managers, the Director of Nursing and the dietician.</p> <p>In an interview on 08/24/17 at 5:05 p.m., the Medical Director acknowledged that he visited Resident #139 on 07/21/17 but did not view or evaluate the pressure ulcers. He shared his expectation that nurses contact him if the wound treatment ordered is not working, if there are complications, or if they feel a hospital evaluation is needed. He stated that wound measurements recorded weekly are "very helpful" in determining</p>	F 314			

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F 314	Continued From page 8 wound progression and/or improvement.	F 314			
F 514 SS=D	<p>In an interview on 08/24/17 at 5:54 p.m., the Director of Nursing stated her understanding of the use of pressure ulcer protocols in monitoring the development and treatment of residents ' pressure ulcers. She shared her expectation that nurses followed the pressure ulcer protocols by measuring wounds, recording observations weekly, and notifying the physician promptly of changes in wound condition.</p> <p>483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>(i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <p>(i) Complete;</p> <p>(ii) Accurately documented;</p> <p>(iii) Readily accessible; and</p> <p>(iv) Systematically organized</p> <p>(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p>	F 514		9/21/17	

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F 514	<p>Continued From page 9</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain complete and accurate records for pressure ulcer status for one of one residents reviewed for pressure ulcers (Resident #139).</p> <p>Findings included:</p> <p>Stage 2 protocols dated 06/23/17 for wounds on the sacrum and left buttocks were present in the Treatment Administration Record (TAR) for Resident #139. The multipage protocols consisted of instructions for the care and treatment of Stage 2 pressure ulcers, orders for nutritional supplements, and preventative maintenance measures. The final page titled "Pressure Ulcer Assessment Sheet" consisted of rows for documenting wound characteristics such as stage; size and depth; appearance; and the presence of drainage, odor or tunneling. Each sheet could record observations and comparisons for 22 weeks.</p> <p>The Stage 2 protocol directed nurses to "measure (in centimeters) the area weekly. Note wound bed tissue appearance, amount/type of drainage and peri-wound details ...skin condition every shift."</p>	F 514	<ol style="list-style-type: none"> 1. Resident #139's Pressure Ulcer Assessment sheet was updated and reviewed with nursing staff to ensure that is a clear understanding of the resident's current status in regards to pressure ulcers. The Clinical Nurse Manager and/or designee will communicate the updated Pressure Assessment sheet information to direct care staff. 2. A audit on all residents with facility acquired pressure ulcers will be conducted to ensure their Pressure Ulcer Assessment sheets are current and accurate. The audit will be completed by the Director of Nursing and/or designee. 3. A weekly audit of Pressure Ulcer Assessment sheets for residents with facility acquired pressure ulcers will be conducted by the Director of Nursing and/or designee. The audit will be completed to ensure Pressure Ulcer Assessment sheets for residents with facility acquired pressure areas are current and accurate. 4. All weekly audit results will be reviewed 		

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F 514	<p>Continued From page 10</p> <p>Resident #139 was admitted 07/01/16 with diagnoses that included unspecified dementia, restlessness and agitation, and anxiety disorder.</p> <p>The most recent Minimum Data Set (MDS) dated 08/01/17 was completed for a significant change in resident ' s condition (a new medical diagnosis of failure to thrive). The MDS indicated that the resident had severe cognitive impairment and was totally dependent for all activities of daily living. The following pressure ulcers were documented: one Stage 2, one unstageable area, and three unstageable deep tissue injuries. No skin integrity issues were recorded on the previous MDS, a quarterly review dated 05/30/17.</p> <p>The care plan for Resident #139 listed measures to address pressure ulcer development such as repositioning the resident, placing "bunny boots" while in bed, applying skin prep to heels twice a day, and using a pressure-relieving mattress and chair cushion.</p> <p>A nursing progress dated 06/23/17 documented the initial assessment and measurement of Stage 2 wounds to the sacrum and left buttocks. There were no progress notes or weekly skin assessments present in the medical record for Resident #139 prior to this date that indicated skin breakdown to this area.</p> <p>A medical order to initiate the "Stage 2 protocol to sacrum and left buttocks" for Resident #139 was dated 06/23/17 and signed by the physician on 07/02/17.</p> <p>No measurements or descriptions of wound status were present on the Pressure Ulcer Assessment sheets for either the Stage 2 sacral</p>	F 514	<p>and discussed in the facility's Quality Assurance Meeting quarterly. Any findings for process improvement will be communicated back to direct care staff by the Clinical Nurse Manager and/or designee.</p>		

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F 514	<p>Continued From page 11</p> <p>or left buttock wounds for Resident #139. A review of nursing progress notes revealed two notes after the initial assessment on 06/23/17 that included measurements and/or descriptions of the wound beds, one dated 08/01/17 and one dated 08/08/17.</p> <p>In an interview on 08/24/17 at 3:09 p.m., Nurse #3 indicated that the clinical nurse manager completed initial measurements when a new pressure ulcer developed. When asked, Nurse #3 was unable to identify who was responsible for measuring wounds on a weekly basis. She stated that unit nurses could chart measurements on either the Pressure Ulcer Assessment sheets or in the nursing progress notes. She indicated that the Pressure Ulcer Assessment sheets were not used much anymore since the facility no longer employed a wound treatment nurse.</p> <p>In an interview on 08/24/17 at 10:59 a.m., Clinical Nurse Manager #1 explained that the unit nurse assigned treatments documented wound measurements. She confirmed that there were no electronic wound treatment forms or notes for Resident #139.</p> <p>In an interview on 08/24/17 at 5:54 p.m., the Director of Nursing shared her expectation that nurses followed the pressure ulcer protocols by assessing and measuring wounds weekly and recording the observations in the resident 's medical record.</p>	F 514		