STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	01/12/2018

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HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

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F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication	F 636		1/31/18

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

Electronically Signed | 01/31/2018

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F 636	Continued From page 1 with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to complete a comprehensive assessment (Minimum Data Set Assessment and Care Area Assessment) within 14 days after admission to the facility for (Resident # 90) for one of 21 sampled residents reviewed for comprehensive assessments. The findings included: Resident #90 was admitted to the facility on 12/11/17 with diagnoses that included, in part, of history of cerebral infarction and aphasia. A review of the Admission Minimum Data Set (MDS) Assessment dated 12/11/17 revealed Resident #90 had severely impaired cognition,	F 636	F 636 • The root cause that led to the deficient practice was one individual failed to follow the established protocol for MDS assessments as referenced in the RAI manual. The CAA for resident 90 was not completed during the time of the MDS assessment. • Plan of correction and procedure for implementing: ¿ The CAA for resident 90 was completed ¿ Inservice Education will be provided for IDT to ensure understanding of CAA completion guidelines as referenced in RAI manual	

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F 636	Continued From page 2 had no speech and his communication status was rarely understood and sometimes understands. A review of the Care Area Assessment (CAA) Summary dated 12/18/17 revealed that the care area triggered for cognitive loss and communication, however, the CAA was not completed. An observation and interview with Resident #90 was completed on 1/9/18 at 10:37 AM. Resident #90 was sitting in his room and there were two communication cards with letters and pictures on his bedside table. The resident shook his head yes/no to questions but was unable to verbalize. An interview was completed with Nurse Aide #2 (NA #2) on 1/11/18 at 9:01 AM. He stated Resident #90 used the call light to summon assistance from staff and then used hand gestures and pointed to the communication board to describe what he needed. An interview was completed with the Speech Therapist/Rehabilitation Director on 1/12/18 at 8:20 AM. She had worked with Resident #90 for cognition and communication and initiated a communication board that he used with staff. She stated she placed a simple board and a more in-depth board at the resident's bedside. She said Resident #90 had global aphasia (an impairment of language that affects receptive and expressive language skills) and primarily used gestures and yes/no responses to communicate needs. An interview was completed with MDS Nurse #1 on 1/12/18 at 10:40 AM. She said when she	F 636	¿ An audit of the most recent assessments for 100% of current residents will be completed to ensure all CAAs that triggered during the assessment were worked and/or care planned ¿ Monitoring We will audit all comprehensive assessments X 4 weeks to ensure CAAS that triggered were worked and/or care planned. Then we will audit 10 random assessments weekly X 4 weeks, and then 10 random assessments monthly X one year. All results will be reported to the Quality Assurance Committee for continued monitoring and improvement. Quality Assurance committee will alter this plan if the improvement is not evident ¿ Person responsible for implementing the plan of correction is the MDS coordinator.	

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F 636	Continued From page 3 completed the MDS she typically completed the CAA at the same time. She stated the CAA's were due on the 14th day after admission and thought it was an oversight that the CAA's for cognitive loss and communication were not completed. An interview was completed with the Administrator on 1/12/18 at 12:59 PM. He said he expected that if a care area was triggered from the MDS that the CAA worksheet be completed and a decision made whether to proceed to care plan for that particular care area.	F 636		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a	F 655		2/9/18

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F 655	Continued From page 4 comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review staff and nurse practitioner interviews the facility failed to complete the baseline care plan for one (Resident #142) of four sampled residents that were new admissions. Resident #142 was assessed as having a left knee immobilizer and was at risk for developing pressure ulcers. The findings included: Resident #142 was admitted to the facility on 12/28/17 with diagnoses including a fracture of the left shin bone with surgical repair on 11/26/17, pressure ulcers on the sacrum and left foot, anemia, gastrointestinal bleed, chronic lung disease with oxygen use, cirrhosis and chronic kidney disease.	F 655	F655 ¿ Plan for correcting specific deficiency oResident #142 was admitted to facility with a knee immobilizer in place. The baseline care plan did not include instructions for knee immobilizer. The root cause of this situation was that the knee immobilizer was not addressed in the discharge summary supplied by the hospital. o The baseline care plan for resident #142 was updated to include the care associated with the knee immobilizer. ¿ Procedure for Implementing plan of correction	

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F 655	Continued From page 5 Review of the hospital discharge orders dated 12/28/17 revealed no orders for use of the immobilizer. Review of the nursing admission assessment dated 12/18/17 revealed the immobilizer was in place. There was no documentation of the skin condition under the immobilizer. The admission skin assessment indicated pressure ulcers were present on the sacrum, left heel, top and sides of the left foot and the left ankle. The baseline care plan dated 12/28/17 did not include the use of the immobilizer. Review of the facility admission orders and orders after admission revealed no instructions for use of the immobilizer. Wound care orders indicated the admission Pressure ulcers were to be treated every day. Review of the physical therapy initial assessment dated 12/28/17 revealed Resident #142 was non-weight bearing and "required a knee immobilizer at all times" per a family member ' s instructions. On 1/12/18 at 10:04 AM, interview with the director of Nursing (DON) explained the nurses on admission, would do a skin assessment, do orders per the discharge summary and verify the orders with the primary physician. She further explained there were no orders regarding the immobilizer and it would not be on the care plan due to lack of physician orders. Nurse practitioner #2, from the primary physician ' s office was interviewed on 1/12/18 at 11:23 AM. She explained she had seen Resident #142 on	F 655	o Baseline care plans will be developed referencing the hospital discharge summary along with the skilled nursing admissions assessments and resident family input. ¿Administrative nurses who are responsible for baseline care plans will be educated on the need to reference the discharge summary, skilled nursing assessments, and eliciting resident family input when developing baseline care plans oAn audit of baseline care plans will be conducted for 100% of the residents admitted to the facility in the past 30 days to ensure the care plan was developed and reflective of the discharge summary, skilled nursing assessments and resident/family input. ¿ Monitoring Procedure For 3 months, all baseline care plans will be reviewed within 72 hours to ensure the care plan was completed, accurate, and shared with the family within 48 hours. The results of this review will be shared with the Quality Assurance committee. The Quality Assurance committee will alter this process should the results not be satisfactory. "The title of the person responsible for implementing this process is the MDS coordinator.	

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F 655	Continued From page 6 the day of admission. She thought the immobilizer was from the orthopedic and would be in place until he returned to the orthopedic. She would expect nursing to inspect the skin under the immobilizer as a nursing protocol and not require an order.	F 655		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(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 observations, record review staff and nurse practitioner interviews the facility failed to check the skin under a left knee immobilizer for one (Resident #142) of 3 sampled residents at risk for developing pressure ulcers. Pressure ulcers developed on the top of the knee. The findings included: Resident #142 was admitted to the facility on 12/28/17 with diagnoses including a fracture of the left shin bone with surgical repair on 11/26/17, pressure ulcers on the sacrum and left foot,	F 686	F686 ¿ Plan for correcting specific deficiency. o Resident 142 was admitted to the facility from the hospital with a knee immobilizer but the discharge summary and physician orders did not include instructions for care or removal of the immobilizer. As a result, skin assessments were completed but did not include assessments under the immobilizer.	2/9/18

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F 686	Continued From page 7 anemia, gastrointestinal bleed, chronic lung disease with oxygen use, cirrhosis and chronic kidney disease. Review of the hospital discharge orders dated 12/28/17 revealed no orders for use of the immobilizer. Review of the nursing admission assessment dated 12/18/17 revealed the immobilizer was in place. There was no documentation of the skin condition under the immobilizer. The admission skin assessment indicated pressure ulcers were present on the sacrum, left heel, top and sides of the left foot and the left ankle. The baseline care plan dated 12/28/17 did not include the use of the immobilizer. Review of the facility admission orders and orders after admission revealed no instructions for use of the immobilizer. Wound care orders indicated the admission Pressure ulcers were to be treated every day. Review of the physical therapy initial assessment dated 12/28/17 revealed Resident #142 was non-weight bearing and "required a knee immobilizer at all times" per a family member ' s instructions. The "Pressure Ulcer Risk Observation" assessment dated 12/28/17 indicated the resident was at high risk for developing pressure ulcers. Review of the nurse ' s notes dated 1/4/18 revealed the wound nurse practitioner documented her visit and assessment of the resident. Resident #142 had no new wounds on his left leg. Existing wounds on the left foot and	F 686	-Immobilizer was removed and orders were obtained for treating the pressure ulcer. ¿ Procedure for implementing plan of correction -For residents admitted with applied devices, physician orders will be obtained for removal and care of the device. ¿ All current residents with applied devices (ie. Splints, immobilizers, etc.) will be assessed for skin issues. In addition, orders for treatment of skin under those devices will be verified. oAll residents will receive weekly skin assessments that include the evaluation of the skin under applied devices, unless contraindicated by physician orders. -Inservice education regarding correct skin assessment protocol will be conducted with nurses. ¿Monitoring Procedure ¿Physician orders for new admissions with applied devices will be audited to ensure orders include care and removal of applied device. ¿Weekly skin assessments for all residents with applied devices will be reviewed by administrative nurses each week for 2 months to ensure assessment completion, and that physician orders were obtained and reflective of care required of resident. ¿Results of both audits will be submitted to Quality Assurance committee each	

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F 686	Continued From page 8 sacrum were measured and assessed. Review of the wound progress note dated 1/4/18 indicated the skin on the left lower extremity was inspected. This note indicated the pressure ulcers on the left foot were caused by an ortho brace the resident had previously worn prior to admission to the facility. Review of the treatment nurse ' s notes revealed a note dated 1/5/18. There was no documentation of the condition of the skin under the immobilizer. Nursing notes from 1/5/18 to 1/9/18 indicated the immobilizer was in place on the left leg. A nursing note on 1/9/18 at 7:51 PM, documented by the treatment nurse, revealed a 2.1 by 2 centimeter (cm) dark purple non blanchable discolored area to the left knee with surrounding skin that was dark blanchable. The area represented a deep tissue injury possibly related to the immobilizer. Below the knee a 2.2 by 1.5 cm dark blanchable area. The immobilizer was removed. Record review revealed a telephone order from the orthopedic surgeon to discontinue the immobilizer. The order was written by the treatment nurse dated 1/10/18. The Admission Minimum Data Set (MDS) dated 1/11/18 revealed Resident #142 had impairment with short and long term memory, had no behaviors, required extensive to total care with bed mobility, transfers, hygiene and toileting. This MDS indicated he was frequently incontinent of bowel and bladder. He was at risk for developing pressure ulcers and had deep tissue injury and stage 3 pressure ulcers on admission.	F 686	month for 2 months. Quality Assurance committee will alter the plan should improvement not be satisfactory. "The Title of the person responsible for implementing this process is the Treatment Nurse.	

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His weight was 89 pounds and height was 70 inches.

Review of the Care Area Assessments (CAA) for the Admission MDS indicated he was at nutritional risk, had multiple pressure wounds, primarily on the foot and the sacrum. The CAA for pressure ulcer indicated he was at risk for developing further ulcers. The CAA for nutrition indicated he was at risk for weight loss and malnutrition. Both areas planned to proceed to care plan.
Observations during wound care on 1/11/18 at 11:00 AM revealed there were three wounds on the top of the left knee. The areas were round, about the size of a nickel and dark to black in color. The skin around the wounds was red and slightly swollen.
Interview with the treatment nurse on 1/11/18 at 11:28 AM revealed she thought the immobilizer had caused the wounds. The immobilizer was discontinued on 1/10/18. The wounds on the left knee were unstageable and treatment orders had been given by the wound Nurse Practitioner (NP) to apply skin prep to the areas.

An interview was conducted with physical therapist (PT) #1 on 1/11/18 at 2:00 PM. The PT#1 explained if a resident was non-weight bearing, the physician would want the immobilizer on the leg and typically one would expect to see orders. Further interview with PT#1 revealed she would expect the care of the knee immobilizer would be nursing. The PT #1 explained care for the immobilizer would include for it to be removed for skin inspection and bathing. The PT#1 had not removed the immobilizer when she worked with him. Inspection of the immobilizer with the PT#1 revealed it was a thick material with some

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padding on the inside. It was one piece, that enabled the leg to rest on it. The sides overlapped in front, with Velcro straps that came from the back of the immobilizer to the front. When the sides overlapped, the straps held it in place. There were plastic "stays" in the back of the immobilizer to help maintain a straight position of the leg. To inspect the knee and sides of the leg, the straps would be loosened and the sides would lie flat exposing the top and sides of the leg.

On 1/12/18 at 8:59 AM, interview with the treatment nurse revealed when wound care was performed each day, she checked the skin around the immobilizer. When asked if she removed the immobilizer to inspect the skin, she replied "no." Further interview revealed she had completed the skin assessment on admission and had not removed the immobilizer due to lack of orders that allowed the removal.

On 1/12/18 at 9:18 AM, interview with NA#1 revealed she had taken care of Resident #142 since admission. She had given the resident a bath since he had been in the facility. She did not remove the immobilizer when she bathed the resident. Further interview revealed she was not aware she was supposed to remove the immobilizer. NA#1 explained she knew what care Resident #142 required by the information on her computerized care plan.

On 1/12/18 at 10:04 AM, interview with the director of Nursing (DON) explained the nurses on admission, would do a skin assessment, do orders per the discharge summary and verify the orders with the primary physician. She further explained there were no orders regarding the

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immobilizer. Staff only knew what the family said. Nursing would wait until therapy assessed him. The DON stated Resident #142 came from another facility that sent him to hospital. The nursing staff thought the immobilizer was for comfort. The DON explained she thought therapy was obtaining orders for the use of the immobilizer.

The therapy manager was in the interview with the DON on 1/12/18 at 10:04 AM. She explained they went by the information provided by the family. The DON explained nursing thought it was for comfort, therapy thought it was due to non- weight bearing.
Clarification and/or information from the orthopedic was not obtained by either nursing or therapy.

Nurse practitioner #2, from the primary physician ' s office was interviewed on 1/12/18 at 11:23 AM. She explained she had seen Resident #142 on the day of admission. The nurses had not completed the skin assessment as he had just arrived. She thought the immobilizer was from the orthopedic and would be in place until he returned to the orthopedic. She would expect nursing to inspect the skin under the immobilizer as a nursing protocol and not require an order.

Interview with the DON on 1/12/18 at 12:02 PM revealed the weekly skin assessments were on Mondays each week. She would expect the aides to remove the immobilizer and complete the bath. She would expect the nurses to remove the immobilizer to complete the skin assessments.

An attempt to interview the orthopedic surgeon by

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	345391	A. BUILDING _____ B. WING _____	01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(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 686	Continued From page 12 phone was made on 1/12/18 at 1:45 PM. A message was left for his assistant to return the call. Interview with Nurse #1on 1/12/18 at 1:49 PM revealed she did a skin assessment on 1/8/18. Nurse #1 explained during the skin assessment she did not remove the immobilizer to check the skin underneath.	F 686		