STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. BUILDING _____ B. WING _____	C 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PLACE NURSING AND REHABILITATION CENTER	9200 GLENWATER DRIVE CHARLOTTE, NC 28262

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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 observation, a nurse practitioner interview, staff interviews and medical record review, the facility failed to provide wound care to a right hip pressure ulcer as ordered by the physician after the dressing was removed during incontinence care. This occurred for 1 of 4 sampled residents (Resident #10). The findings included: Resident #10 was admitted to the facility on 3/29/19. Diagnoses included pressure ulcer sacral region, stage 2, anemia, diabetes mellitus 2, cerebral infarction with hemiplegia, dementia, cognitive communication deficit, percutaneous gastronomy tube and severe protein calorie malnutrition, among others. An admission Minimum Data Set assessment dated 4/5/19, assessed Resident #10 with severely impaired cognition, rarely/never	F 686	University Place Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction as required by Federal and State regulations and statutes applicable to long term care providers. This plan does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this plan does not constitute an agreement by the facility that the surveyor□s findings or conclusions are accurate, that the findings constitute a deficiency, or the scope or severity regarding any of the deficiencies cited are correctly applied. F686 Corrective action has been accomplished for the alleged deficient practice in regards to resident #10. On 05/17/19	6/14/19

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

Electronically Signed | 06/13/2019

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F 686	Continued From page 1 understood, total assistance with bed mobility, always incontinent of bowel/bladder, two unhealed stage 2 pressure ulcers, and at risk for developing more pressure ulcers. Review of Resident #10's care plan and the Care Area Assessment for April 2019 identified him at risk for further skin impairment due to a history of pressure ulcers, extensive/total dependence on staff for bed mobility/transfers, bowel/bladder incontinence, tube fed due to nothing by mouth status, history of weight loss due to nutritional deficits, and bed fast. Interventions included in part, to provide wound care as ordered by the physician. Review of the April 2019 - May 2019 wound ulcer flow sheets revealed the unhealed stage 2 pressure ulcers Resident #10 had on admission were resolved and he developed a new stage 2 pressure ulcer to his right trochanter (upper part of thigh bone) on 4/21/19. The pressure ulcer measured 3 centimeters by 2 centimeters with 80% granulation (viable) tissue. Review of the physician's order dated 4/21/19 revealed the pressure ulcer treatment was to cleanse the pressure ulcer with wound cleaner and apply a hydrocolloid dressing (wafer type dressing with a gel for absorption) every 5 days and as needed. A wound ulcer flow sheet dated 5/16/19 recorded the pressure ulcer to his right hip measured 2 centimeters by 2 centimeters with a depth of 0.1 centimeters. On 5/16/19 at 5:45 PM Nurse Aide (NA) #1 was observed in Resident #10's room and stated she	F 686	Duoderm dressing was applied per physician□s order by treatment nurse. All residents with pressure ulcers have the potential to be affected by the same alleged deficient practice. On 05/17/19 an audit was conducted by Director of Nursing (DON) and staff nurse for all residents with pressure ulcers to verify that dressings were completed per order. All dressings noted to be completed as ordered. Measures put into place to ensure that the alleged deficient practice does not recur include: In-service education was initiated by Staff Facilitator and Director of Nursing on 5/17/19 and completed on 6/14/19. All nurses are to complete treatments as ordered by physician on an as needed basis as well as scheduled when there is no treatment nurse in the building and/or if the treatment nurse is unable to attend to resident. On 5/17/19 the staff facilitator and DON initiated an in-service education to the CNAs to instruct them if a dressing comes off and/or is soiled during care the CNA should wait for the assigned nurse or treatment nurse to come replace the dressing before getting the resident up. In-service was completed by 6/14/19. This will be reviewed in new employee orientation. PRN nurses will be in-serviced upon next scheduled shift to work. An audit was initiated on 5/30/19 by the Director of Nursing and Staff Facilitator to monitor that treatments were being completed per physician□s order on residents with pressure ulcers. Audits will	

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F 686	Continued From page 2 had just provided him with incontinence care. An adult brief was in place, but not fastened. The right hip area was visible and the stage 2 pressure ulcer to the right hip was observed uncovered and without a dressing in place. NA #1 stated during the observation that when she provided incontinence care moments before, Resident #10 did not have a dressing in place to his right hip pressure ulcer and that Nurse #1 (Treatment Nurse) was aware. She further stated that Resident #10 had a pressure ulcer to his right hip that was slightly open, it was her first time assigned to his care, and she did not receive report regarding his uncovered pressure ulcer from the assigned NA (NA #2) on the prior shift (7:00 AM - 3:00 PM). An interview occurred on 5/17/19 at 11:10 AM with NA #2 who stated she was the assigned NA for Resident #10 on 5/16/19 for the 7:00 AM - 3:00 PM shift. NA #2 said she worked with Resident #10 routinely and was aware that he had a pressure ulcer to his right hip area. NA #2 stated when she arrived to work on 5/16/19 and conducted her first round of incontinence care before breakfast, Resident #10 had a dressing in place to his right hip pressure ulcer, but when she provided her second round of incontinence care before lunch, Resident #10 did not have a dressing in place to his pressure ulcer. She could not recall the exact time, but stated, "I think it (dressing) must have come off when I removed the brief, I told Nurse #2 and she told me to tell Nurse #1 (Treatment Nurse) which I did. Nurse #1 (Treatment Nurse) said she would take care of it." Nurse #1 (Treatment Nurse) entered Resident #10's room on 5/16/19 at 5:58 PM with supplies	F 686	be completed on residents with pressure 2 times per week for 4 weeks, then monthly x 3 months. The Director of Nursing, Assistant Director of Nursing or Staff Facilitator will present the findings and recommendations at monthly QI committee meeting. QAPI/QI committee will evaluate for continued compliance for 3 months.	

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F 686	Continued From page 3	F 686		

to treat the pressure ulcer and stated that she had just been informed that Resident #10 did not have a dressing in place to the stage 2 pressure ulcer on his right hip. Nurse #1 (Treatment Nurse) observed Resident #10's wound during the interview and stated she would dress the stage 2 pressure ulcer. She further stated that she last saw the stage 2 pressure ulcer for Resident #10 one day last week, but that she could not recall which day. She also stated that the pressure ulcer had no current signs of infection and no signs of deterioration compared to when she last observed it.

A follow up interview occurred on 5/16/19 at 6:00 PM with Nurse #1 (Treatment Nurse). During the interview, Nurse #1 stated that she needed to clarify her previous interview and advised the surveyor that the 7:00 AM - 3:00 PM NA for Resident #10 informed her around 1:45 PM on 5/16/19 that Resident #10 did not have a dressing in place to his stage 2 pressure ulcer. Nurse #1 stated she forgot that when she spoke to the surveyor earlier. She stated she had no explanation as to why she did not provide wound care to Resident #10 until around 6:00 PM on 5/16/19 other than she just got busy and failed to ask another nurse for help.

An interview occurred on 5/16/19 at 6:05 PM with Nurse #2 who revealed she was the assigned Nurse for Resident #10 that day on the 3:00 PM -11:00 PM shift, but that she had not worked with this Resident before. She further stated that she had not observed his skin thus far on her shift, she was unaware that he had a stage 2 pressure ulcer without a dressing in place. She stated she had not been advised that Resident #10 needed pressure ulcer care.

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On 5/17/19 at 11:00 AM Nurse #3 was interviewed. She stated that she was the assigned Nurse for Resident #10 on 5/16/19 for the 7:00 AM - 3:00 PM shift. Nurse #3 stated that the assigned NA (NA #2) for the same shift advised her sometime after lunch that when she provided incontinence care to Resident #10, the Resident did not have a dressing in place to his stage 2 pressure ulcer. Nurse #3 stated she advised the NA to tell Nurse #1 (Treatment Nurse) so that a dressing could be applied. Nurse #3 further stated she did not observe the Resident's skin and she did not provide pressure ulcer care because Nurse #1 (Treatment Nurse) said she would provide the care.

An interview with the Administrator and an observation of the uncovered right hip stage 2 pressure ulcer for Resident #10 occurred on 5/16/19 at 5:55 PM. The Administrator observed Resident #10 in bed without a dressing to his stage 2 pressure ulcer and confirmed that the pressure ulcer should have a dressing intact.

An interview occurred on 5/16/19 at 6:15 PM with the Assistant Director of Nursing and the Director of Nursing. Both stated that a resident with a physician's order for pressure ulcer care should receive the care as ordered by the physician. They both stated that Resident #10 had a physician's order for routine pressure ulcer care and care as needed and they expected this order to be followed. The interview revealed when Nurse #1 (Treatment Nurse) was advised that Resident #10 did not have a dressing in place to his stage 2 pressure ulcer, Nurse #1 (Treatment Nurse) should have applied a dressing or asked another nurse for help because of the Resident's

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F 686	Continued From page 5 high risk for further skin breakdown due to his incontinence status and compromised skin integrity. An interview with the Nurse Practitioner (NP) occurred on 5/17/19 at 11:30 AM. The interview revealed that the stage 2 pressure ulcer to Resident #10's hip should have a dressing in place due to his risk for further skin breakdown, incontinence status and risk of infection to an open/undressed pressure ulcer. The NP further stated that from before lunch to around supper was a long time for Resident #10 to go with his pressure ulcer undressed/exposed because he was incontinent.	F 686		