STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING ______ B. WING ______	C 08/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

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E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 8/13-14/2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# V97211	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation survey was conducted on 8/13-14/2020. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event # V97211. 1 of 1 allegations were substantiated and resulted in deficiency F 580.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(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	F 580		8/31/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/28/2020

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 580	Continued From page 1 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 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). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record reviews, and staff interviews, the facility failed to notify a resident representative (RP) of a worsening pressure ulcer for 1 of 3 residents reviewed for pressure ulcers (Resident #1).	F 580	- Resident #1 was transferred to the hospital on 8/3/2020 and no longer a resident of the facility. On 8/27/2020, Facility Nurse Educator	

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F 580

Continued From page 2

Findings included:

Resident #1 was admitted to the facility on 7/13/2019 with a most recent readmission date of 5/13/2020 and a discharge date of 8/3/2020. Diagnoses for Resident #1 included end-stage renal disease, muscle weakness and atrial fibrillation.

The most recent quarterly Minimum Data Set (MDS) assessment dated 5/7/2020 assessed Resident #1 to be cognitively intact, with a Brief Interview for Mental Status (BIMS) of 13 out of 15 (cognitively intact). The MDS did not document the presence of pressure ulcers for Resident #1.

A BIMS assessment completed on 5/19/2020 assessed Resident #1 to have a BIMS of 09 (moderately cognitively impaired).
Resident #1 ' s medical chart was reviewed. A nursing note date 5/29/2020 written by the Staff Development Coordinator (SDC) noted Resident #1 had a new Stage 2 pressure ulcer on his buttocks that measured 1.8 centimeters (cm) by 2.3 cm by 0.1 cm. The note documented the physician (MD) and the Nurse Practitioner had been notified. The note did not document the family had been notified of the new pressure ulcer.

A nursing note written by Nurse #6 dated 6/3/2020 noted Resident #1 Stage 2 pressure ulcer to the left buttocks and it measured 1.5 cm by 1.8 cm by 0.2 cm and the area around the wound was excoriated. The note did not document the family was notified of the pressure ulcer.

F 580

educated Nurse #2, 3, 4, and 6 to complete and document RP notification of any changes in wound progression, including changes to the treatment of the wound. Nurse #1 will be educated on 8/31/2020.

- On 8/27/2020 Facility Nurse Educator conducted 100% audit of residents with wounds, to ensure RP notification of ongoing status of wounds. Results of the monitoring revealed 100% compliance and was shared with the Administrator and Director of Nursing.

- Facility Educator or designee will educate all nurses to complete and document RP notification of any changes in wound progression, including changes to the treatment of the wound, by 8/31/2020. Any nurse who does not receive the training by 8/31/2020 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift at the facility upon their return. This education is included in the new employee education.

Facility Educator or designee will weekly add all new wounds to new Wound Audit Tool implemented on 8/27/2020. The tool includes RP notification of any changes in wound progression, including changes to the treatment of the wound.

- Beginning 9/4/2020, Director of Nursing designee will utilize new Wound Audit Tool to audit 100% of residents with wounds, once a week for compliance with RP

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F 580	Continued From page 3 A nursing note written by Nurse #1 dated 7/11/2020 documented Resident #1 had excoriation of his buttocks and sacrum (lower back) and the area was cleansed with soap and water and a barrier cream was applied. The note further documented Resident #1 ' s continued loose stools related to an infection and the MD had been notified. The note did not document the family had been notified of the change in skin condition. A nursing note dated 7/20/2020 written by Nurse #2 documented the deterioration of the skin on Resident #1 ' s buttocks and the appearance of a deep tissue injury that measured 3.3 cm by 2.1 cm, as well as an open areas on the coccyx that measured 3.0 cm by 1.4 cm by 0.3 cm. The note documented no signs or symptoms of infection and the area was cleansed and a dressing was applied. The note documented the MD was notified. The note did not document the family had been notified of the change in skin condition or the open pressure ulcer. A nursing note dated 7/30/2020 written by Nurse #1 documented that Resident #1 had an appointment at the wound clinic and he had returned to the facility with new MD orders. A nursing note dated 8/1/2020 written by Nurse #5 documented Resident #1 was confused "off and on". A nursing note dated 8/2/2020 written by Nurse #4 documented the family had been notified Resident #1 was more confused. The note did not document the family had been notified of the pressure ulcer.	F 580	notification with any changes in wound progression, including changes to the treatment of the wound. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 580	Continued From page 4 Nurse #6 and the SDC were interviewed on 8/13/2020 at 2:40 PM. Nurse #6 reported she had been performing weekly wound care for all residents in the facility for the past several months. Nurse #6 reported Resident #1 had not specifically told her to not contact his family, but he was alert and oriented at that time and he was his own representative. The SDC explained if a resident was their own representative, staff did not need to call the family to notify of changes. The SCD reported Resident #1 had been alert and oriented but had a change in cognition after his hospitalization and readmission to the facility on 5/13/2020. The SCD reported she was not certain if Resident #1 was able to cognitively process the information regarding the breakdown of his skin. An interview was conducted with Nurse #1 on 8/13/2020 at 3:08 PM. Nurse #1 reported she had provided care to Resident #1 and had noted the change in skin condition on 7/11/2020. Nurse #1 reported that Resident #1 was his own representative and he was able to process information and he was aware that he had wounds on his buttocks. Nurse #1 reported Resident #1 was able to answer questions appropriately on 7/11/2020. Nurse #1 was unable to remember if Resident #1 specifically asked her not to call his family. A phone interview was conducted with Nurse #4 on 8/13/2020 at 10:02 PM. Nurse #4 reported she had contacted Resident #1 ' s family on 8/2/2020 because had had increased confusion. Nurse #4 reported she had not mentioned the pressure ulcers during her conversation with the family. Nurse #3 was interviewed by phone on 8/13/2020	F 580		

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F 580	Continued From page 5	F 580		

at 10:30 PM. Nurse #2 reported she had written the note on 8/1/2020 regarding the change in the pressure ulcer on Resident #1 ' s buttocks. Nurse #3 reported she had notified the MD and completed a change in condition form for Resident #1. When asked why she had not notified the family of the change in Resident #1 ' s wound, Nurse #3 reported she read the change of condition report dated 7/20/2020 and felt that the MD had been notified and did not think the family needed notified. Nurse #3 reported she could not remember if Resident #1 was confused on 8/1/2020.

Nurse #2 was interviewed on 8/14/2020 at 9:12 AM. Nurse #2 reported she had documented the pressure ulcer change on 7/20/2020 after being notified by a nursing assistant that the skin on Resident #1 ' s buttocks had changed. Nurse #2 reported that on 7/20/2020 when she provided care to Resident #1, he was confused and was unable to retain information. Nurse #2 reported she should have notified the family of Resident #1 regarding the change in skin and the pressure ulcers because Resident #1 was unable to understand her.

A nursing assistant #1 (NA) was interviewed on 8/14/2020 at 9:27 AM. NA #1 reported that Resident #1 was forgetful and required instructions repeated many times. NA reported she had provided care for Resident #1 and when the skin on his buttocks opened and became dark, she notified the nurse.

An interview was conducted with the resident liaison (RL) on 8/14/2020 at 10:39 AM. The RL reported Resident #1 ' s family was notified about his change in cognition and they had been

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F 580	Continued From page 6 interested in obtaining power of attorney forms in July 2020. The Director of Nursing (DON) was interviewed on 8/14/2020 at 1:30 PM. The DON reported she was not certain why the RP of Resident #1 was not notified of the change in his buttocks skin and the formation of pressure ulcers. The DON reported that Resident #1 had been alert and oriented and the cognitive change was recent. The DON reported if a resident was confused, she expected the family to be notified of changes in the resident condition.	F 580		