STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 01/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	**6001 WILORA LAKE ROAD CHARLOTTE, NC 28212**

(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
E 000	Initial Comments The survey team entered the facility on 01/19/2021 to conduct an unannounced COVID-19 Focused Infection Control Survey and exited on 01/19/2021. Additional information was obtained offsite on 01/20/2021 and 01/21/2021. Therefore, the exit date was 01/21/2021. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# FU2411.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 01/19/2021 to conduct an unannounced COVID-19 Focused Infection Control Survey and Complaint Investigation and exited on 01/19/2021. Additional information was obtained offsite on 01/20/2021 and 01/21/2021. Therefore, the exit date was 01/21/2021. The facility was found 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. Two of the 11 complaint allegations were substantiated resulting in a deficiency. Event ID #FU2411.	F 000		
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	F 686		2/17/21

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

Electronically Signed | 02/09/2021

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F 686	Continued From page 1 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, staff, hospice nurse and nurse practitioner interviews, and record review, the facility failed to obtain treatment orders and document assessments of a sacral pressure ulcer for 1 of 3 sampled residents with pressure ulcers (Resident #1). The findings included: Resident #1 was readmitted to the facility on 01/07/2021 with diagnoses which included a long-term mental disorder and hypertension. Resident #1's hospital discharge summary dated 01/07/2021 documented Resident #1 developed a sacral pressure ulcer during the hospitalization. The necrotic sacral pressure ulcer was debrided. The hospital discharge summary contained no measurements or orders for treatment of the sacral pressure ulcer. A nursing admission data collection note dated 01/07/2021 documented Resident #1 was alert with memory problems. The assessment documented the presence of a sacral pressure ulcer. There was no documentation of description or measurements of the pressure ulcer. Resident #1's care plan revised on 01/07/2021 documented the presence of a pressure ulcer on	F 686	1. The facility failed to obtain treatment orders and document assessments for Resident #1 with a sacral pressure ulcer. Wound Nurse obtained a treatment order from Nurse Practitioner on 1/19/21 and Resident #1 was seen by VOHRA Wound Physician on 1/27/21. The Wound Nurse was reeducated on 1/19/21 by the Director of Nursing to measure wounds weekly to include Hospice residents and to ensure documentation of assessments weekly. 2. On 1/25/21 Nursing Management, to include Director of Nursing, Unit Manager, and Wound Nurse completed 100% skin sweeps on current residents to identify wounds and ensure treatment orders in place. Nursing Management also reviewed resident with wound Treatment Administration Record to ensure orders in place and correct. Issues identified were corrected and/or treatment orders obtained for wounds. 3. The Director of Nursing implemented a wound/ Skin referral form for nurses to notify the wound nurse of any new skin issues. this training completed on 2/8/21. Designated mail box was implemented	

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F 686	Continued From page 2 the sacrum. Interventions included administration of treatments as ordered, assess, record monitor wound healing with weekly treatment documentation to include measurement of area of skin breakdown's width, length, depth, and type of tissue. Resident #1's readmission orders dated 01/07/2021 contained no orders for treatment of the sacral pressure ulcer. Resident #1 received admission to hospice care on 01/14/2021. Observation with the wound nurse on 01/19/2021 at 10:56 AM revealed Resident #1's sacrum covered with a dry clean dressing. The wound nurse removed the sacral dressing. Resident #1's sacral pressure ulcer was approximately 5 centimeters (cm.) by 7 cm. with a darkened center approximately 1 cm. by 2 cm. Interview with the wound nurse on 01/19/2021 at 11:20 PM confirmed the absence of treatment orders for Resident #1's sacral pressure ulcer. The wound nurse announced she obtained orders today (01/19/2021) for a wet to dressing sacral dressing daily. The wound nurse explained she did not obtain treatment orders since Resident #1 received hospice care and thought the hospice nurse obtained treatment orders. The wound nurse reported Resident #1's sacral pressure ulcer had not been measured since admission on 01/07/2021. Interview with Nurse Aide (NA) #1 on 01/19/2021 at 9:30 AM revealed Resident #1 required total assistance with care. NA #1 reported Resident #1 had a sacral dressing. If the dressing became soiled, NA #1 informed the nurse who changed the dressing. NA #1 reported the dressing was	F 686	out side the wound nurse door for any referral. The wound nurse is now required to assess all new admissions/readmissions within 24 hours of admission. The Director of Nursing and/or RN Nurse Manager will re-educate Licensed Nurses on the clinical guidelines for skin and wounds. Also on new wound/skin referral form and protocol. The wound nurse is responsible to notify the wound doctor of any new skin issues and obtain treatment order as directed. On admission/re-admission the licensed nurse will evaluate the resident□s skin, document/describe wounds, and initiate treatment orders, if needed. The education will be completed by 2/17/21. This education will be provided to new employees as part of new hire orientation, contract staff and agency staff, this education will be provided prior to starting work. Current staff will be educated prior to their next scheduled shift. During Clinical morning meeting the Director of Nursing, Wound Nurse, Unit Manager, and MDS will review new admissions/readmissions to ensure residents admitted with wounds have treatment orders and documentation/description of wound in place. 4. The Director of Nursing and/or Nursing designee to perform Quality Improvement monitoring of 5 residents with wounds have treatment orders and documented assessments to be completed 2 times a	

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F 686	Continued From page 3 changed daily by the nurse. During an interview with Nurse #1 on 01/19/2021 at 12:20 PM, Nurse #1 revealed she admitted Resident #1 on 01/07/2021. Nurse #1 reported she completed a full body assessment on Resident #1 and orally reported the presence of the sacral wound to the wound nurse. Nurse #1 explained she changed Resident #1's dressing daily and relied on the wound nurse to obtain orders for the dressing change. Nurse #1 reported Resident #1's sacral pressure ulcer appeared to slightly improve with the daily wet to dry dressing changes. Nurse #1 reported she did not measure or document a description of the pressure ulcer. During an interview with the hospice nurse on 01/19/2021 at 12:35 PM, the hospice nurse reported Resident #1 was admitted to hospice care on 01/14/2021 and received the first skilled nurse visit on 01/15/2021. The hospice nurse reported he assessed the sacral wound as unstageable. The hospice nurse estimated the wound measured 12 cm. by 8 cm. with a dark eschar tissue center. The hospice nurse reported he cleansed and changed the sacral dressing. The hospice nurse explained Resident #1's hospice care consisted of pain management and end of life care. The hospice nurse reported the facility would be responsible for treatment and documentation of the sacral pressure ulcer. Telephone interview with the Nurse Practitioner (NP) on 01/19/2021 at 12:58 PM revealed the NP was aware of Resident #1's sacral pressure ulcer and relied on the facility staff to obtain treatment orders and document assessments of the pressure ulcer.	F 686	week for 4 weeks, then weekly x 2 months, and then 1 x monthly for 3 months. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 2/17/21. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee Members consist of but not limited to Executive Director, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct Care giver. Quality Improvement Quality Monitoring schedule modified based on findings. AOC Date: 2/17/21	

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F 686	Continued From page 4 Interview with the Director of Nursing (DON) on 01/19/2021 at 1:05 PM revealed the wound nurse should have obtained treatment orders from the NP or hospice practitioner and document an assessment which should include a description and measurement of Resident #1's sacral pressure ulcer.	F 686		