

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

PRINTED: 09/03/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/02/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRIAN CENTER SOUTHPPOINT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>6000 FAYETTEVILLE ROAD</b> <b>DURHAM, NC 27713</b>	
(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 000	INITIAL COMMENTS	F 000		
F 686 SS=D	<p>Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)</p> <p>§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(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</p> <p>(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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, resident interview, family interview, staff interview, and physician interview, for one (Resident # 2) of three sampled residents with pressure sores, the facility failed to thoroughly assess and initiate clear treatment orders when a resident was identified to have a pressure sore so that all nurses could follow through with an approved plan of care for the pressure sore. The findings included:</p> <p>Record review revealed Resident # 2 was admitted to the facility on 7/7/21 with a lumbar fracture. Additionally, the resident had diagnoses of a history of breast cancer, chronic obstructive</p>	F 686	<p>Resident #2 has appropriate treatment orders in place with review by the DON on 8/2/21.</p> <p>All residents with pressure ulcers have the potential to be affected by the allegedly deficient practice.</p> <p>On 8/4/21, a 100% audit of all residents that have skin pressure areas and appropriate physician orders was completed by the Treatment Nurse/ADON/ Director of Nursing to ensure all residents with pressure skin areas had appropriate monitoring and</p>	8/13/21

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

TITLE

(X6) DATE

Electronically Signed

08/06/2021

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 686	<p>Continued From page 1</p> <p>pulmonary disease, heart disease, gout, and hypertension. The resident was 92 years of age at time of facility admission.</p> <p>Resident # 2's admission minimum data set assessment, completed on 7/14/21, coded the resident as having no pressure sores; as cognitively impaired; as needing extensive assistance with bed mobility and hygiene needs; as having a suprapubic catheter; and as being frequently incontinent of stool.</p> <p>Review of Resident # 2's care plan revealed a problem was added on 7/7/21 noting that the resident was at risk for pressure sore development. The care plan directed that skin checks be performed weekly and the resident should be turned and repositioned to decrease pressure. The resident's care plan was updated on 7/19/21 to reflect multiple other interventions. One intervention was listed as, "follow facility policies/protocols for the prevention/treatment of skin breakdown."</p> <p>According to the record, Resident # 2 went to her neurosurgeon on 7/21/21. A review of the neurosurgery consult revealed the following notation. "She reports some back pain today but is mainly concerned over some buttock pain at an area she describes as a pressure sore." The neurosurgeon did not note any exam of the pressure sore; only that Resident # 2 complained about it.</p> <p>On 7/22/21, Nurse # 3 noted on a skin assessment that Resident # 2 had a new pressure sore. There was no description or size of the pressure sore. Nurse # 3 noted she started a barrier cream treatment.</p>	F 686	<p>treatment orders in place. No other residents were identified to have been affected.</p> <p>Current Licensed Nursing Staff will receive re-education by the Director of Nursing/Assistant Director of Nursing and Treatment Nurse related to Our Skin Management System with focus on proper treatment, monitoring and management of a resident's skin condition. This education will be completed by 8/11/21.</p> <p>100% audit of all Resident's with skin pressure areas will be monitored by the Nurse Supervisors weekly x 4 weeks then monthly x 1 month utilizing the Audit Treatment and Services to Prevent/Heal Pressure Ulcers tool. This audit is to ensure all Resident's with pressure skin areas have the appropriate monitoring, assessment and treatment plans in place. Any employee will be immediately re-educated by the Nurse Supervisor for any identified areas of concern. The Director of Nursing will review and initial the Treatment and Services to Prevent/Heal Pressure Ulcers Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concerns were addressed.</p> <p>All newly hired Licensed nursing staff will also receive this Plan of Correction education by the Treatment Nurse/ADON/Director of Nursing.</p> <p>The Director of Nursing will present the findings of the Treatment and Services to</p>		

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F 686	<p>Continued From page 2</p> <p>Nurse # 3 was interviewed on 7/30/21 at 4:45 PM and reported the following. When she looked at the resident's skin on 7/22/21, the resident had an area on her coccyx which was red but not broken open. She applied barrier cream and felt that was an appropriate treatment at the time given the observation of the area. According to Nurse # 3, it was the facility protocol to use barrier cream on all residents whose skin might be red but not broken.</p> <p>On 7/22/21 the NP (Nurse Practitioner) saw Resident # 2 and documented it had been communicated to her that Resident # 2 had a small area on her buttocks, the area was not visualized by the NP during the exam, and Resident # 2 was agreeable to being seen by the facility's wound physician.</p> <p>The facility's speech therapist was interviewed on 7/30/21 at 3:30 PM and reported the following. The facility has an ambassador program and specific staff are assigned to communicate with residents/ families when they have problems in order to resolve them. She was assigned as Resident # 2's ambassador. On 7/22/21 she had been contacted by Resident # 2's family member regarding Resident # 2 having a skin issue. The family member stated to the ST that she (the family member ) had been present on the evening of 7/21/21 when staff were providing care to Resident # 2, and she (the family member) had seen that the resident was starting to have some skin breakdown. The ST spoke to the facility's treatment nurse on 7/22/21 about the skin issue and he indicated he would look at the pressure sore. According to the ST, the facility treatment nurse did not look at the resident's pressure sore</p>	F 686	<p>Prevent/Heal Pressure Ulcers Tool to the Executive Quality Assurance (QAPI) Committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Treatment and Services to Prevent/Heal Pressure Ulcers Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.</p> <p>The Director of Nursing will be responsible for implementing this plan of correction effective 8/13/21.</p>		

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F 686	<p>Continued From page 3</p> <p>on 7/22/21 and so she mentioned it to him again on 7/23/21.</p> <p>Resident # 2's responsible party (RP) was interviewed on 7/30/21 at 11:30. The RP reported the following. She was in the clinical health care field. On 7/21/21, the neurosurgeon had let her know there was a concern about Resident # 2 starting to have a pressure sore. She visited on the evening of 7/21/21 and looked at Resident # 2's skin herself while staff cared for her. The RP reported she saw that the resident's skin was not broken, but it appeared to the RP that Resident # 1 was developing a Stage 1 pressure sore. Therefore, she had called the Resident's ambassador the next morning.</p> <p>Review of physician orders revealed the first order entered into Resident# 2's medical record for the care of the pressure sore was dated 7/25/21. The order was for Santyl to be applied to the Coccyx after cleansing the wound with soap and water. The wound was then to be covered with a dry dressing and changed daily.</p> <p>Review of Resident # 2's July 2021 Treatment Administration Record (TAR) revealed no documentation of dressing changes to the pressure sore on 7/22/21; 7/23/21; 7/24/21; or 7/25/21. The first dressing change signed as completed was on 7/26/21.</p> <p>The facility's treatment nurse was interviewed on 7/30/21 at 2:55 PM via phone. The treatment nurse was interviewed again via phone on 7/30/21 at 4:45 PM with the Director of Nursing (DON). The treatment nurse reported the following during the interviews. He recalled he first looked at Resident # 2's pressure sore on</p>	F 686			

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F 686	<p>Continued From page 4</p> <p>7/23/21 because the ST had talked to him about it. When he initially looked at the pressure sore, he found it to be small; approximately 2 cm (centimeters) X 3 cm but with necrosis on the top of it. Per his observation and the wound protocols, he started a treatment of Santyl ointment to the area and a covering of a dry dressing. (Santyl is an enzymatic debriding ointment that removes dead tissue from wounds so that they can start to heal). He did not write the order in the record until 7/25/21. He had been very busy at the time when he initiated the order. He applied the Santyl dressing on 7/23/21 and 7/24/21 but did not document the application of the dressing.</p> <p>During the interview with Resident # 2's responsible party on 7/30/21 at 11:30 AM, she reported the following. The treatment nurse had contacted her on 7/23/21 and let her know Resident # 2's pressure sore had yellow slough in the wound bed and they would be using Santyl ointment on the wound. One evening after 7/23/21 (on which date it had been established the pressure sore needed the enzymatic debridement ointment) she arrived to find no dressing on Resident # 2's pressure sore. She spoke to Nurse # 1 who told her there were no orders for any type of dressing and that she needed an order to apply a dressing.</p> <p>Nurse # 1 was interviewed on 7/30/21 at 5:26 PM and reported the following. She recalled she had worked on the evening of 7/24/21 and Resident # 2's dressing had become soiled and dislodged during care. She had found no orders for the wound care. Therefore, she left the pressure sore open to air, placed the information in the facility communication book noting that they needed</p>	F 686			

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F 686	<p>Continued From page 5</p> <p>clarification of wound orders, and passed along to the next nurse that orders needed to be clarified.</p> <p>Nurse # 2 was the nurse who replaced Nurse # 1 on 7/24/21 at 11:00 PM. Nurse # 2 was interviewed on 8/2/21 at 7:00 AM and stated she covered Resident # 2's pressure sore that night with a dry dressing but she did not apply Santyl to the pressure sore.</p> <p>Nurse # 3 was interviewed on 7/30/21 at 4:45 PM with the DON. Nurse # 3 stated she had worked 16 hours beginning at 7:00 AM on 7/25/21 and she had applied a Santyl dressing that day but not documented it. To her knowledge the dressing had stayed on. According to Nurse # 3 she knew the type of dressing to apply because she had been present on 7/23/21 when the treatment nurse looked at it.</p> <p>According to the record, on 7/28/21 the facility's wound physician saw Resident # 2 and debrided the pressure sore. He noted it was unstageable due to necrosis and measured 2.5 X 2.5 X 0.1 cm. with 70 % necrosis and 30% granulation tissue.</p> <p>The DON was interviewed on 7/30/21 at 4:45 PM and again at 5:55 PM. The DON reported the following. The facility has a very detailed wound protocol that had been approved by all the medical physicians. Once a pressure sore is identified, a treatment can be initiated based on the wound protocol and the assessment of the wound. Then the wound physician follows up when he comes each week. There is a very lengthy education component for the nurses to complete for the wound protocol. If a nurse had not completed the wound protocol training, then</p>	F 686			

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F 686	<p>Continued From page 6</p> <p>they could call her and she could explain what treatment to initiate or they could contact the physician or the facility's treatment nurse if there was a question regarding missing treatment orders. This is what should have been done when Resident # 2's dressing came off. It had been a very busy weekend from 7/23/21 to 7/25/21 and the facility typically did get the orders in the system, but the DON validated no treatment orders had been put in Resident # 2's medical record until 7/25/21 although the resident was observed to have a pressure sore on 7/22/21. The DON also stated Resident # 2 had been out of the facility for a lengthy time on 7/21/21 for her neurology consult and had been placed on a stretcher for a great deal of this time. She felt this could have contributed to tissue damage which quickly grew worse.</p> <p>A follow up interview was conducted with the DON on 8/2/21 at 9:50 AM. According to the DON when a routine pressure sore treatment order is established and initiated then a PRN (as needed) treatment is also initiated and included on the TAR for the same treatment. This allows for the nurses to know and sign off for the appropriate treatment if a routine pressure sore dressing becomes soiled or in need of replacement.</p> <p>Resident # 2 was observed on 7/30/21 at 11:00 AM as Nurse # 4 provided care to the pressure sore. The pressure sore was observed to be approximately the size of two quarters. It had approximately 50% yellow slough and 50 % red granulation tissue. Directly following the pressure sore care, Resident # 2 commented that there had been a 24- hour period the week before during which the staff "did not put a patch on." Resident # 2 said, "I think it was</p>	F 686			

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F 686	Continued From page 7 miscommunication."  The facility's wound physician was interviewed on 7/30/21 at 4:10 PM and reported the following. It was important to address a pressure sore as quickly as possible once it is identified. It was also important to keep it covered in order to protect it from stool. He had seen and evaluated Resident # 2. The wound physician stated wounds can get bad very quickly and just because the wound had quickly grown worse did not necessary mean that the facility had failed to care for it. In Resident # 2's case, the wound could have deteriorated regardless of appropriate dressing changes. This was because of her advanced age, mobility problems which contributed to offloading of the wound, and possibly her nutritional status.	F 686			
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)  §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.  §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 842		8/13/21	



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F 842	<p>Continued From page 8</p> <p>(iv) Systematically organized</p> <p>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law;</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(i)(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 842			

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F 842	<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:</p> <p>Based on record review and staff interviews the facility failed to assure the medical records were complete related to dressing changes for two (Residents # 1 &amp; # 2) of three sampled residents with dressing changes. The findings included:</p> <p>1. Record review revealed Resident # 2 was admitted to the facility on 7/7/21 with a lumbar fracture.</p> <p>Nurse # 3 documented on a 7/22/21 skin assessment that Resident # 2 had developed a pressure sore. There was no notation where the pressure sore was located. The nurse made a notation on the skin assessment sheet that a barrier cream application was initiated.</p> <p>There were no pressure sore treatments documented in Resident # 2's medical record on 7/23/21, 7/24/21 or 7/25/21.</p> <p>On 7/25/21 the first pressure sore treatment order was entered into Resident # 2's record. It directed staff to cleanse the wound and apply Santyl ointment. The pressure sore was then to be covered with a dry dressing.</p> <p>The facility treatment nurse was interviewed on 7/30/21 at 2:55 PM via phone. The treatment nurse was interviewed again via phone on</p>	F 842	<p>Resident #1 no longer resides in the facility. Resident #2 has appropriate treatment orders in place with review by the Director of Nursing on 8/2/21.</p> <p>All residents with orders for treatments to pressure ulcers have the potential to be affected by the allegedly deficient practice.</p> <p>Director of Nursing/Assistant Director of Nursing/Treatment Nurse/Unit Coordinators reviewing the treatment Administration Records for the last 30 days for omissions in documentation. Follow-up with the assigned license nurse will be taken to include: late entry documentation if treatment was completed/appropriate disciplinary action and continued education. MD will be notified if indicated related to treatment omissions. Documentation of Audit utilizing the "Treatment Administration Record QAPI" Form. Audit Completion Date 8/11/21.</p> <p>Licensed Nursing Staff will be receiving education on Documentation of Treatments Re-education which will include review of Treatment</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>BRIAN CENTER SOUTHPPOINT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>6000 FAYETTEVILLE ROAD</b> <b>DURHAM, NC 27713</b>		
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F 842	<p>Continued From page 10</p> <p>7/30/21 at 4:45 PM with the Director of Nursing (DON). The treatment nurse reported the following. Per his observation and the physician approved wound protocols, he started a treatment of Santyl ointment to the area on 7/23/21. He applied the dressing on 7/23/21 and 7/24/21 but did not document the dressing changes or enter the treatment orders into the record.</p> <p>Nurse # 2 was interviewed on 8/2/21 at 7:00 AM and reported the following. She worked on the night shift which began on 7/24/21 at 11:00 PM. Although she did not document it, she had applied a dry dressing to Resident # 2's pressure sore during her shift.</p> <p>Nurse # 3 was interviewed on 7/30/21 at 4:45 PM with the DON. Nurse # 3 stated she had worked 16 hours beginning at 7:00 AM on 7/25/21 and she had applied a Santyl dressing that day but did not document the dressing application.</p> <p>The DON was interviewed on 7/30/21 at 4:45 PM and reported that treatment orders should be entered into the record when initiated. The DON validated pressure sore treatment orders had not been entered into the computer for Resident # 2 until 7/25/21. According to the DON, nurses should document dressing changes. The DON validated there was no documentation of dressing changes for 7/23/21, 7/24/21, and 7/25/21.</p> <p>2. Resident #1 was admitted to the facility on 7/3/2021 and discharged on 7/12/2021. Resident #1 was not in the facility long enough to have a minimum data set assessment completed.</p> <p>Resident #1 had physician orders initiated on</p>	F 842	<p>Administration Records each shift, documentation completion of the treatment, progress note if the treatment is not done and why. This education will be completed by the Director of Nursing/Assistant Director of Nursing/Treatment Nurse/or Unit Coordinators by 8/11/21.</p> <p>All newly hired Licenses nurses will also receive this Plan of Correction education.</p> <p>DON/ADON/Unit Coordinators will conduct random audits of the treatment administration records weekly x 4 weeks and monthly x 1 month.</p> <p>The Director of Nursing will present the findings of the Treatment Administration Record QAPI Form to the Executive Quality Assurance (QAPI) Committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Treatment Administration Record QAPI Form to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.</p> <p>The Director of Nursing is responsible for implementing this plan of care effective 8/13/21.</p>		

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F 842	<p>Continued From page 11</p> <p>7/9/2021 for wound care for a left above the knee amputation. The wound was to be cleansed with normal saline, silver alginate applied to the wound bed, covered with a dry dressing, and secured. The wound care was ordered to be completed daily every day shift.</p> <p>Resident #1 had an additional physician order initiated on 7/9/2021 for wound care on the left anterior thigh. The wound was to be cleansed with normal saline, silver alginate applied to the wound bed, covered with an abdominal gauze pad for drainage, wrapped with Kerlix gauze (bandage rolls), and secured. The wound care was ordered to be completed daily every day shift.</p> <p>Resident #1 also had a physician order initiated on 7/9/2021 for wound care to the left groin. The wound was to be cleansed with normal saline, silver alginate applied to the wound bed, covered with an abdominal gauze pad for drainage, wrapped with Kerlix gauze and secured. The wound care was ordered to be completed daily every day shift.</p> <p>Documentation on the treatment administration record revealed the ordered wound care treatments initiated on 7/9/2021 for Resident #1 were not documented as completed on 7/11/2021 and were left blank.</p> <p>An interview was conducted on 7/30/2021 at 1:53 PM with Nurse #3, who was assigned to perform the wound treatments for Resident #1 on 7/11/2021 on the day shift. Nurse #3 stated the hall nurses were assigned to perform the wound treatments on the weekends. Nurse #3 stated she did perform the wound treatments for</p>	F 842			

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

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F 842	Continued From page 12 Resident #1 on 7/11/2021. Nurse #3 remembered asking for the nurse aide's assistance in helping with the dressing change. Nurse #3 revealed it was a busy day and perhaps she forgot to document she did the treatments for Resident #1.  An interview was conducted on 8/2/2021 at 12:49 PM with the Director of Nursing (DON). The DON stated Nurse #3 had a rough day on 7/11/2021 because she was working a 16-hour shift and had to send two residents to the hospital. The DON explained Nurse #3 had to make numerous phone calls to the physician and she probably forgot to go back and document she did the treatments for Resident #1.	F 842			