STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	07/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLOW RIDGE OF NC	237 TRYON ROAD RUTHERFORDTON, NC 28139

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews the facility failed to develop a care plan for the prevention, and care of a resident who was high risk and developed a pressure ulcer of the sacrum for 1 of 2 residents (Resident #1). The findings Included: Resident #1 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was at risk of receiving pressures ulcers and required extensive assistance for bed mobility. The MDS assessment further revealed Resident #1 was cognitively intact. Review of Resident #1 medical record reviewed no care plan or interventions for pressure ulcers. Review of a physician order [REDACTED]. The physician ordered for the wound to be cleansed with wound cleaner, apply collagen sheet, and cover with foam dressing. This was to be implemented daily every Monday, Wednesday, and Friday. Review of Resident #1 consultation with the wound doctor dated 7/6/20 revealed Resident #1 had an unstageable wound to the sacrum and a shear wound to the right buttock. Interview with the MDS Coordinator #1 on 7/21/20 at 3:05 pm revealed a comprehensive care plan was to be developed within 8 days of admission. MDS Coordinator #1 revealed a comprehensive care plan should have been implemented at the time the resident developed the wound and should have been updated when the resident developed an infection. Interview with the Assistance Director of Nursing (ADON) on 7/21/20 at 3:22 pm revealed Resident #1 had a wound to his sacrum. The ADON indicated she did not document her initial observation of Resident #1's wound. The ADON revealed that a care plan should have been implemented when the area of pressure was identified. Interview with the Director of Nursing (DON) on 7/21/20 at 2:44 pm revealed that there was a dark spot on Resident #1 at the time of admission on 6/15/20. The DON indicated when a resident had skin break down, a care plan should be implemented. The DON revealed that she did not know that there was not a care plan for Resident #1. The care plan should have been developed at the time the wound was identified.
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and physician interviews, the facility failed to provide care according to recommendations to promote healing of an in-house acquired sacral wound for 1 of 2 residents (Resident #1) that resulted in an infection. The findings included: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the admission nursing assessment dated [DATE] revealed Resident #1 required total dependence for bed mobility, and transfers. Resident #1's skin was warm, dry, and intact. The Braden Scale dated 6/15/20 for Resident #1 revealed a score of 15, which indicated he was at risk for skin breakdown. The Admission Minimum Data Set ((MDS) dated [DATE] revealed Resident #1 was cognitively intact, required extensive assistance of 2 staff persons for bed mobility and had no areas of skin breakdown. Review of physician order [REDACTED].#1. This physician order [REDACTED].#1's record related to the wound. Continued review of the physician orders [REDACTED].#1's sacral wound that stated cleanse area with wound cleanser, apply collagen sheet, cover with foam dressing every day shift every Monday, Wednesday, and Friday. Review of Resident #1's weekly skin check dated 7/2/20 indicated the resident had discoloration to the middle of his sacrum. The skin check further revealed the Director of Nursing (DON) was notified and no dressing present upon the observation. Review of Resident #1's medical record revealed no care plan or interventions for pressure ulcers. A review of the Wound Care Physician consult dated 7/6/20 revealed a debridement was completed to Resident #1's sacral wound. The Wound Care Physician indicated Resident #1 was currently on a Group 1 mattress (mattress, pressure pad, overlay). The note continued that Resident #1 had an unstageable pressure ulcer to the sacrum and shearing to the right buttock. Recommendations for treatment stated; wound care to sacrum, cleanse with wound cleanser, pat dry, apply calcium alginate with silver, cover with gauze dressing, apply skin prep around area every day shift. Other recommendations included off-load wound, Group 2 mattress (pressure relieving mattress), limit sitting to 30 minutes, and reposition per facility protocol. His documentation stated Resident #1's care was discussed with the Director of Nursing (DON) and an assigned nurse (not named). Review of physician order [REDACTED]. Review of physician order [REDACTED].#1 was to receive [MEDICATION NAME] 500 milligrams (mg) for a wound infection for 14 days. An interview on 7/21/20 at 1:45pm with the Wound Care Nurse revealed she was notified of any wound development by nursing staff. In the instance she was not available, unit coordinators completed wound care. The Wound Care Nurse stated she recalled being notified that Resident #1 had developed a wound 3 weeks into admission. She further revealed that Resident #1 was admitted to the facility during her absence and the resident was documented as having no pressure areas upon admission. Observation of Resident #1's sacrum on 7/1/20 revealed a closed necrotic area and a wound consult was written. The Assistant Director of Nursing (ADON) was interviewed on 7/21/20 at 3:21pm and it was reported to her by a nursing assistant (not named) on 7/2/20 that Resident #1 had a wound on his bottom. She stated the wound to his bottom appeared to be scar tissue. Physical therapy was notified, and a wedge cushion, bedrest, and repositioning was implemented every 2 hours. A wound consult was further ensured. The ADON stated the Wound Care Physician saw Resident #1 on 7/6/20. Resident #1's sacral wound was necrotic was debrided. The ADON revealed she had not documented any wound treatment provided by the Wound Care Physician. She stated she should have documented the onset of the wound and interventions recommended. A continued interview with the Wound Care Nurse on 7/22/20 at 1:08 pm revealed she was notified of Resident #1's sacral wound by the ADON on 7/1/20. Her observation of Resident #1's sacrum revealed a small area with necrotic tissue. The Wound Care Nurse stated wound measurements should have been documented in the nursing progress notes, but she was unaware if she had documented Resident #1's wound status. The Wound Care Nurse stated she implemented a wound consult and further included preventative measures on 7/1/20. The preventative measures put into place were cleanse area with wound cleanser, apply collagen sheet, cover with foam dressing every day shift every Monday, Wednesday, and Friday. The Wound Care Nurse indicated she was not present to round with the Wound Care Physician on 7/6/20. She stated the nurse who made rounds with the Wound Doctor should have ensured wound care orders were communicated. On 7/22/20 at 2:18pm the DON was interviewed which revealed she was present when the Wound Care Physician debrided Resident #1's wound on 7/6/20. The DON stated the Wound Care Physician's recommendations were sent through an electronic portal. The Wound Care Nurse would receive the recommendations through the portal and process any orders. The Wound Care Nurse would provide recommendations to the Primary Care Physician (PCP) or Family Nurse Practitioner for approval. Resident #1's new wound care orders were put into place on Saturday, 7/11/20. An interview on 7/23/20 at 10:22am with the Wound Care Physician revealed Resident #1 had a large necrotic area which required extensive debridement. The Wound Care Physician revealed he completed Resident #1's debridement and was followed by the ADON. The Wound Care Physician further stated the DON was present as well. Upon exiting the facility, the Wound Care Physician stated he provided the facility with recommendations for care and treatment and the consult was available to the facility via an electronic portal following his assessment. He stated the facility should have put recommendations into place on 7/6/20 following Resident #1's debridement to promote healing. The Wound Care Physician

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

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 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) stated following Resident #1's debridement he had placed recommended wound dressings to the resident's sacrum to include alginate with silver. On 7/23/20 at 10:55am an interview with the Primary Care Physician (PCP) revealed Resident #1 did not have any wounds upon admission to the facility. He stated recommendations from the Wound Care Physician would be available to the facility via an electronic portal. The PCP revealed the facility should document the resident's wound status and implement recommendations. The PCP stated he was unsure if it was a delay in care or whether it was a delay with receiving wound care recommendations. The PCP stated the facility dropped the ball on documenting Resident #1's wound status and ensuring recommendations were followed. The resident's sacral wound did not require an antibiotic until 7/11/20. Continued interview on 7/24/20 at 9:20am with the Wound Care Physician revealed the continued use of the collagen dressing as ordered by the Wound Care Nurse would have been okay for use but would have been contraindicated. The Wound Care Physician indicated the use of the calcium alginate he recommended on 7/6/20 would have served as moisture to the wound bed and contained microbial properties. Collagen would not manage the moisture without the use of the calcium alginate. After Resident #1's debridement the Wound Care Physician stated his 7/6/20 recommendations would have been his preference for wound healing.