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

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

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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). Findings included: Resident #1 was admitted to the facility on [DATE] with a most recent readmission date of [DATE] and a discharge date of [DATE]. [DIAGNOSES REDACTED]. The most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] 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. 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. 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 [DATE]. 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 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 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.

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