STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345216	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westfield Rehabilitation and Health Center	3100 Tramway Road Sanford, NC 27330

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** 50642 Based on record review, and staff and Medical Director (MD) interviews, the facility failed to notify the MD when a stage three pressure ulcer was identified for 1 of 1 resident reviewed for pressure ulcer (Resident #71). Findings Included: Resident #71 was admitted to the facility on [DATE] for fracture of right femur with a plan for discharge home after rehabilitation. Resident #71 was discharged from the hospital after surgery to repair a right femur fracture. Review of the Wound Care Nurse's assessment on admission on 08/02/24 revealed she noted redness to sacral area. On 08/23/24 at 12:31 pm a telephone interview with Nurse #1 revealed on 08/13/24 she was called to the resident's room by the (Nurse Aide) NA providing care to Resident #71. She reported the sacral pressure ulcer appeared to have slough, she measured it and left a message for the Wound Care Nurse to further assess. Wound Care Nurse's note dated 08/14/24 revealed that a sacral pressure ulcer was noted by the 11:00 PM to 7:00 AM shift nurse. This nurse reported that the resident had a stage 3 sacral ulcer. Description of the wound was 70% slough and 30% granulation tissue, unstageable and measured 2.7 cm (cm) in length and 2. 5 cm in width. There was no documentation the Medical Director was notified. On 08/23/24 at 09:23 am an interview with Medical Director (MD) revealed that Resident #71 was admitted on [DATE] and he was first informed of the stage three pressure ulcer on 08/16/24. The MD stated the delay in his notification was acceptable if another clinician had been notified.

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.

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

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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** 50642 Based on record review, observations, and staff and Medical Director (MD) interviews, the facility failed to do a weekly skin assessment which resulted in the delay of identification of a stage three pressure ulcer for 1 of 1 resident reviewed for pressure ulcer (Resident #71). The findings included: Resident #71 was admitted to the facility on [DATE] for fracture of right femur with a plan for discharge home after rehabilitation. Resident #71 was discharged from the hospital after surgery to repair a right femur fracture. Review of the Wound Care Nurse's assessment on admission on 08/02/24 revealed she noted redness to sacral area. Further review of records revealed that on 08/02/24 a verbal order for zinc oxide external ointment 20% (topical), apply to sacrum topically two times a day was initiated and to do weekly skin checks. A care plan dated 08/05/24 revealed interventions of assistance with incontinence care and bed mobility to reduce the risk of pressure ulcer development. The admission Minimum Data Set (MDS) dated [DATE] revealed that Resident #71 was moderately cognitively impaired. Resident #71 was coded to have no pressure ulcer and was incontinent of bladder with substantial /maximal assistance for shower/bathing and for lower body dressing and was dependent on staff for toileting. There was no documentation of a weekly skin assessment in Resident #71's medical record. On 08/22/24 at 10:57 am, an interview with the Wound Care Nurse revealed that she was responsible for the completion of the admission skin assessment for Resident #71. Nurse stated that the sacral skin redness was blanchable and didn't indicate any pressure ulcer on admission. The Wound Care Nurse reported she put the order in place for the zinc oxide twice a day and weekly skin checks. The Wound Care Nurse reported that the nurses were responsible for the weekly skin checks. The interview further revealed that the weekly skin check scheduled on 08/09/24 was not done. On 08/23/24 at 12:31 pm a telephone interview with Nurse #1 revealed on 08/13/24 she was called to the resident's room by the (Nurse Aide) NA providing care to Resident #71. She reported the sacral pressure ulcer appeared to have slough, she measured it and left a message for the Wound Care Nurse to further assess. Wound Care Nurse's note dated 08/14/24 revealed that a sacral pressure ulcer was noted by the 11:00 PM to 7:00 AM shift nurse. This nurse reported that the resident had a stage 3 sacral ulcer. Description of the wound was 70% slough and 30% granulation tissue, unstageable and measured 2.7 cm (centimeters) in length and 2.5 cm in width. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of records revealed that Resident # 71 was seen by Wound Care Doctor on 08/21/24 for a wound on sacrum, left buttock. The Wound Care Doctor documented the wound was unstageable (due to necrosis), had moderate serous exudate and measured 3.5 cm (length) x 3.5 cm (width) and no measurable depth. Further review of records revealed treatment for the necrosis (the death of most or all the cells in a tissue) required surgical excisional debridement (the removal of damaged tissue from a wound). The Wound Care Doctor's orders for treatment plan was for calcium alginate with silver (absorbs bacteria and fluid from the wound) to be applied once daily for 30 days. Santyl (removes dead tissue from wound) apply once daily for 30 days. May use medical grade honey if unable to use Santyl. Cover with a gauze island with a border. Apply once daily for 30 days. On 08/22/24 at 9:01 am an observation of wound care completed by Wound Care Nurse revealed treatment of sacral wound with Santyl, calcium alginate with silver, and silicone bordered dressing daily. Resident #71 was observed on an air mattress and required assistance with turning. Resident #71 was lying on her left side while wound care was being completed. Resident #71 expressed discomfort prior to treatment but was medicated by the assigned nurse prior to initiation of treatment. The wound bed was clean, and there was no drainage and no odor. Interview with Nurse Aide (NA) #1 on 08/22/24 at 10:22 am revealed that Resident #71 was incontinent and required assistance with turning. The interview further revealed Resident #71 gets a shower twice a week and any skin concerns were addressed with the nurse. NA #1 denied that resident was refusing showers and no abnormal skin issues reported. On 08/22/24 at 11:30 am, an interview with MDS Nurse revealed skin assessments were completed by the unit nurse but if the unit was busy, this was completed by the Wound Care Nurse or the support nurse. During the interview the MDS Nurse reported that she was unsure of any standardized risk assessment tool used on admission. On 08/22/24 at 03:25 pm, an interview with Dietitian (RD) revealed that her initial assessment for Resident #71 was completed on 08/13/2024 and all the resident had was a surgical wound. The interview further revealed that she did not visually see the resident but was told that resident completed 0-75% of meals, and nothing further needed to be done as the resident was already on Pro-stat. Mighty Shake (changed to Ensure due to resident preference) ordered as soon as wound was noticed to assist with nutritional intake. The Dietitian revealed that the process for reporting of wound was via email by the Wound Care Nurse. Interview of the Support Nurse on 08/22/24 at 03:45 pm revealed that she was assigned to the care of Resident #71 on admission. The Support Nurse reported that the expectation was that the nurse assigned to the resident would complete the skin assessment if the Wound Care Nurse was not around. The Support Nurse revealed Resident # 71's skin assessment was completed by the Wound Care Nurse on 08/02/24 and the order for skin checks were flagged automatically in the electronic chart. On 08/23/24 at 09:23 am an interview with Medical Director (MD) revealed that Resident #71 was admitted on [DATE] and he was first informed of the stage three pressure ulcer on 08/16/24. The MD stated the delay in his notification was acceptable if another clinician had been notified. Interview with Nurse Consultant on 08/23/24 at 11:31am revealed that it was possible for the wound to occur given the appropriate circumstances as Resident #71 fell at home prior to admission, and this may have affected her risk for skin breakdown. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/23/24 at 11:31 am an interview with the Administrator revealed a plan was set in place after Resident # 71's wound was found. She reported that these steps would be identifying the factors, refer to dietitian, refer to wound care physician, refer to PT for cushions and the need for air mattress. The interview further revealed it was not the expectation for the skin to go from blanchable to stage 3 ulcer. The facility provided the following corrective action plan with a completion date of 08/19/24. 1. Corrective action for resident (s) affected by the alleged deficient practice. -Head to toe assessment was completed on the affected resident, MD (Medical Director), RD (Registered Dietitian) and Family updated. New orders were initiated for wound. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. -On 08/16/2024 head to toe skin assessments were completed on all current residents by the assigned nurse. This was completed on 08/16/2024. The results included: There were no new skin issues that were identified. 3. Measures/Systemic changes to prevent reoccurrence of deficient practice: Education (change of condition, pressure ulcer and treatment of pressure ulcer). -On 08/16/2024 the Staff Development Coordinator (SDC) initiated in-service of all licensed nurses and Certified Nurse Assistants (CNA), including agency on change of condition, pressure ulcer assessment and treatment of pressure ulcers. -The Director of Nursing (DON) will ensure that any of the above identified staff who do not complete the in-service training by 8/19/24 will not be allowed to work until the training is completed. 4. Monitoring procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. -The DON/designee will monitor the skin assessment process weekly for 2 weeks and monthly for 3 months for compliance with the skin/wound process. Reports will be presented to the weekly quality assurance (QA) committee by the wound nurse or DON to ensure corrective action initiated as appropriate. Compliance will be monitored, and ongoing auditing program reviewed at the monthly QA Meeting. The QA Meeting is attended by the Administrator, DON, MDS Coordinator, Wound Nurse, Therapy, Health Information Manager and the Dietary Manager. The corrective action plan was completed on 08/20/2024. Onsite validation was completed on 08/23/24 through staff interviews and record review. Staff were interviewed on training, reporting and timing of reporting. A review of the audits of the residents' notes for skin checks for all residents was noted to be completed on 08/16/24. The review of the audit tools that the facility provided were noted to be completed 08/15/24 to 08/19/2024. The facility's corrective action plan completion date of 08/20/2024 was validated.