STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PEAK RESOURCES-OUTER BANKS	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

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 0224 **Level of harm** - Actual harm **Residents Affected** - Some	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, physicians, and staff interview, the facility neglected to identify and remove wound packing left inside a sacral pressure ulcer for 1 of 6 residents (Resident #11) investigated for wound care which resulted in the decline of the sacral pressure ulcer and development of an abscess. Findings included: Resident #11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #11's care plan initiated 4/29/16 revealed the resident was care planned for a pressure ulcer on the sacral area. The goal was that the resident's pressure ulcer would decrease in size by next review. The interventions were to measure and record descriptions of the area, location, and size weekly, and to treat the area per physician orders. Review of the resident's quarterly minimum (MDS) data set [DATE] revealed the resident was assessed as having an unstageable pressure ulcer. The measurements of the pressure ulcer were 2.5 centimeters by 2.0 centimeters. Review of a physician's orders [REDACTED]. Record review of the resident's Treatments Administration History for the dates of 7/18/16 - 7/22/16 revealed Resident #11 was documented to have received sacral wound care. According the documentation, the wound was packed with a fine mesh gauze, soaked with normal saline, covered with dry dressing, and secured with tape on 7/18/16, 7/19/16, 7/20/16, and 7/21/16 by Treatment Nurse #1 per physician's orders [REDACTED]. Review of the weekly pressure ulcer documentation dated 7/21/16 at 3:23 PM signed by Treatment Nurse #1 revealed the sacral pressure ulcer was recorded as an unstageable pressure ulcer, 0.8 centimeters by 0.8 centimeters by 0.1 centimeters. Undermining (meaning the wound continued under intact skin) was noted at 12 o'clock 1.5 centimeters, 3 o'clock 0.5 centimeters, 6 o'clock 0.5 centimeters, and 9 o'clock 0.5 centimeters. 100% of the wound bed was documented to be granulation tissue (new healthy tissue growth that occurs during the wound healing process). Pressure ulcer care was documented as performed. Review of a physician's orders [REDACTED]. The order to pack the wound with normal saline soaked fine mesh gauze was discontinued on this date. Review of the weekly pressure ulcer check dated 7/27/16 revealed the wound was documented to be an unstageable pressure ulcer, 0.8 centimeters by 0.8 centimeters by 0.1 centimeters. Undermining was noted at 12 o'clock 1.5 centimeters, 3 o'clock 0.5 centimeters, 6 o'clock 0.5 centimeters, and 9 o'clock 0.5 centimeters. The wound was 100% granulation tissue. There was no documentation of fine mesh gauze observed in the wound. Review of the weekly pressure ulcer check dated 8/4/16 revealed the wound was documented to be an unstageable pressure ulcer, 1.0 centimeters by 1.0 centimeters with no depth. Undermining was noted at 12 o'clock 1.0 centimeters, 3 o'clock 2.0 centimeters, 6 o'clock 1.0 centimeters, and 9 o'clock 0.5 centimeters. The wound was 100% granulation tissue. There was no documentation of fine mesh gauze observed in the wound. Review of a wound care physician's consult note dated 8/11/16 revealed the resident was assessed at a doctor's office by Physician #1. Physician #1 discussed options with the family for continued treatment. The order for the [MEDICATION NAME] dressing was continued as a result of the consult. There was no documentation of fine mesh gauze observed in the wound. Review of the resident's quarterly minimum (MDS) data set [DATE] revealed the resident was assessed as having an unstageable pressure ulcer. The measurements of the pressure ulcer were 1.5 centimeters by 1.5 centimeters with no depth. There was no documentation of fine mesh gauze observed in the wound. Review of the weekly pressure ulcer check dated 8/19/16 revealed the wound was documented to be an unstageable pressure ulcer, 0.5 centimeters by 0.5 centimeters with no depth. The wound was 100% granulation tissue. There was no documentation of fine mesh gauze observed in the wound. Review of the weekly pressure ulcer check dated 8/25/16 revealed the wound was documented to be an unstageable pressure ulcer, 0.3 centimeters by 0.3 centimeters with no depth. The wound was 100% granulation tissue. There was no documentation of fine mesh gauze observed in the wound. Review of the weekly pressure ulcer check dated 8/29/16 revealed the wound was documented to be an unstageable pressure ulcer, 0.5 centimeters by 0.5 centimeters with no depth. The wound was 100% [MEDICATION NAME] tissue. There was no documentation of fine mesh gauze observed in the wound. Review of the weekly pressure ulcer check dated 9/5/16 revealed the wound was documented to be a stage II pressure ulcer, 0.3 centimeters by 0.3 centimeters with no depth. The wound was 100% [MEDICATION NAME] tissue. There was no documentation of fine mesh gauze observed in the wound. Review of the weekly pressure ulcer check dated 9/13/16 revealed the wound was documented to be a stage II pressure ulcer, 0.2 centimeters by 0.2 centimeters with no depth. The wound was 100% [MEDICATION NAME] tissue. There was no documentation of fine mesh gauze observed in the wound. Review of the weekly pressure ulcer check dated 9/26/16 revealed the wound was documented to be a stage I pressure ulcer, 0.5 centimeters by 0.5 centimeters with no depth. The wound was 100% [MEDICATION NAME] tissue. There was no documentation of fine mesh gauze observed in the wound. Review of Resident #11's progress note dated 10/5/16 revealed during the routine dressing change to sacral pressure ulcer, Treatment Nurse #2 noted a large 6 centimeters by 6 centimeters soft fluid-filled packet at the wound. The skin color at the wound was noted to be red. Treatment Nurse #2 notified the Medical Director and an appointment was scheduled with Physician #1 the next day. Review of a wound care physician's consult note dated 10/6/16 revealed Physician #1 assessed Resident #11's pressure ulcer at his doctor's office. The assessment revealed the sacral ulcer had increased pain and redness. A large abscess was noted to be 12 centimeters by 12 centimeters by 5 centimeters on the resident's sacrum. Physician #1 performed an incision and drainage of the abscess and discovered 6 inches of fine mesh gauze in the subcutaneous tissue. Review of Resident #11's most recent Minimum (MDS) data set [DATE] revealed the resident had a stage III pressure ulcer. Review of Resident #11's most recent weekly pressure ulcer check dated 11/28/16 revealed the resident's sacral pressure ulcer measurements were 2.5 centimeters by 1.5 centimeters by 0.7 centimeters. Review of the resident's active [DIAGNOSES REDACTED]. During a telephone interview on 11/30/16 at 12:20 PM, Physician #1 stated when he observed Resident #11 on 8/11/16 he did not observe any fine mesh gauze in the wound. He further stated he only continued the ordered [MEDICATION NAME] dressing following this visit. Physician #1 stated that the facility placed a fine mesh gauze in the pressure ulcer on the sacrum

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 0224 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 1) intentionally or unintentionally at some point while the wound was still open. He further stated the gauze was either lost or forgotten about and the wound healed over the gauze. Physician #1 further stated that he had no doubt the gauze was the cause of the abscess that Resident #11 developed and he treated on 10/6/16. Physician #1 stated that someone in the facility's staff had made a mistake and either not followed the order correctly or had lost a gauze in the wound somehow. He further stated that the fine mesh gauze should not have been left in the wound. During an interview on 11/30/16 at 2:45 PM Treatment Nurse #2 stated Resident #11's sacral pressure ulcer was first identified on 4/27/16. Treatment Nurse #2 stated that she was not the wound care nurse at that time. She stated that when she began care of Resident #11's sacral pressure ulcer, the skin was healing and intact. She stated that the wound care orders at that time were for [MEDICATION NAME] dressing changed every three days and as needed. She further stated she had never packed the wound prior to it being reopened 10/6/16. Treatment Nurse #2 stated that she felt the resident had progressed well and she believed care was about to be discontinued, but on 10/5/16 she changed the resident's dressing and observed a fluid pack around the wound. She stated she alerted the medical director and the resident was sent to Physician #1's office the next day for wound care. She added a piece of wound packing in the resident's pressure ulcer was found by Physician #1. Treatment Nurse #2 stated that when changing a [MEDICATION NAME] dressing, she would inspect the wound for healing and make measurements. She further stated that when she began to care for the resident's wound full time, the wound had already closed and the skin was intact so she was unable to inspect inside the wound. During an interview on 11/30/16 at 5:22 PM the Director of Nursing (DON) stated she that she expected the wound would be inspected by the wound care nurse upon return to the facility from the doctor's visit with new orders. She further stated her expectation was anything noted foreign or unusual in the wound during the assessment to be documented and reported. The Director of Nursing stated the nurses informed her of the abscess found on 10/6/16. The DON stated she believed the abscess could have caused harm to the resident, but did not know if the abscess was a result of the gauze being left in the resident. During an interview on 11/30/16 on 5:57 PM Treatment Nurse #2 stated she covered the Treatment Nurse #1's shift on 7/15/16 and then again on 7/23/16. During these dates the [MEDICATION NAME] dressing was ordered. She stated she did not remember ever placing fine mesh gauze in the resident's wound and that she checked the dressing each day and performed the weekly wound assessments as ordered. She further stated that due to the abscess Resident #11 had developed, the resident had increased reports of pain to the area. She stated that the resident was receiving pain medications for the increased pain. Treatment Nurse #1 no longer worked for the facility. Attempts were made to interview Treatment Nurse #1 with no return calls received.
F 0242 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure each resident has the right to have a choice over activities, their schedules and health care according to his or her interests, assessment, and plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews and record review, the facility failed to honor the personal preference for time to get up for 1 of 4 sampled residents (Resident #1) and failed to honor the resident's wishes for a shower and toilet use for 1 of 4 sampled residents (Resident #3). Findings included: 1. Resident #1 was readmitted to the facility on 2/19/16 with [DIAGNOSES REDACTED]. The quarterly Minimum (MDS) data set [DATE] indicated Resident #1 was cognitively intact and required extensive assistance for activities of daily living. He was totally dependent on one staff member for bathing. He had functional limitations on both sides of his lower extremities and used a wheel chair for mobility. He was independent with locomotion after help with set up. A review of the care plan last reviewed on 5/10/16 revealed Resident #1 had limited ability to bathe himself due to [MEDICAL CONDITION]. The interventions included he required one person to provide assistance for bathing. Resident #1's preference for rising early had not been addressed on the care plan. On 11/29/16 at 10:00 AM Resident #1 was observed lying in bed. The resident stated he preferred to get up around 7:00 AM, but staff (unidentified by resident) had told him there was not enough staff to get him up at that time. Resident #1 identified Nursing Assistant (NA) #3 as getting him out of bed at his preferred time. During an interview with Treatment Nurse #2 on 11/30/16 at 11:35 AM she stated Resident #1 preferred to be out of bed early and that he required 2 persons and the lift to get him out of bed. She stated in the past he was up by 6:00 AM but not now. She was unsure of why he was not up early because he had always wanted to be out of bed early. Resident #1 was interviewed on 11/30/16 at 11:45 AM. He stated he had just received a shower. He reported that when he gets out of bed depends on which staff are working. He stated he preferred to get out of bed early and the facility staff were aware of his preference. He stated he was not willing to get up at 3:00 AM when the staff said they could get him up. Resident #1 also stated when NA #3 was working he got up per his preference but otherwise he was at the mercy of the NAs who were working. An interview was held with Nursing Supervisor (NS) #1 on 11/30/16 at 2:00 PM. She stated she was aware Resident #1 liked to be up early, but had been told by the 11:00 PM to 7:00 AM shift they were unable to get him up at his preferred time due to only one NA and one nurse working on the hall. NS #1 added the NAs who worked with Resident #1 had told her that during his preferred time to get out of bed, they were doing their last rounds and the nurses were giving medication. NS #1 stated she had suggested the NAs start their rounds 15 minutes earlier in order to accommodate Resident #1, but had been told no by the NAs. The NS confirmed the facility had been fully staffed on 11/29/16 during the 7:00 AM to 3:00 PM shift and had no reason for Resident #1 to have still been in bed at 10:00 AM. During an interview with NA #3 on 11/30/16 at 2:37 PM he stated he was unsure how the NAs working the 11:00 PM to 7:00 AM shift worked to get their job done and that they have their own way of doing things. NA #3 reported he knew the Resident #1 cared about when he got out of bed. NA #3 said he took it into consideration when Resident #1 wanted to get out of bed so he would adjust his break and meal schedule to ensure Resident #1 was out of bed on time. NA #3 also stated he went to the resident's room at 5:00 -5:30 AM and offered to get him up. NA #3 reported that Resident #1 would occasionally say no but most of the time said yes. NA #3 reported he only worked 2 days per week. On 11/30/16 at 3:45 PM the Director of Nursing (DON) reported she did not know Resident #1 wanted to get up early. She stated Resident #1 would wake up at 6:45 AM but that was at the change of shift so it was difficult to preform care at that time. She stated she became aware of Resident #1's preference to be out of bed early when it was verbalized during a staff meeting 2 weeks ago. 2. Resident #3 was admitted on [DATE] with [DIAGNOSES REDACTED]. Progress notes, dated 7/5/16 at 1:55 PM indicated the resident was status [REDACTED]. The resident had a full length cast to mid-thigh with toes exposed. The 7/12/16 Admission Minimum Data Set (MDS) indicated Resident #3 required extensive assistance for toilet use, was frequently incontinent of bowel and bladder and no toileting program had been attempted. Choosing the type of bath was coded as not very important to the resident. Review of nurse's notes revealed Resident #3's cast was removed on 8/2/16. On 8/9/16, Resident #3 filed a grievance related to not being transferred to the toilet when she asked and also had concerns about bathing. The Director of Nursing (DON) at the time documented she spoke with the Nursing Assistant (NA) and the NA stated baths were given. The resident was advised staff would be instructed on the resident's preference for toileting. The form did not list the names of staff that were interviewed about the resident's choices for toilet use and bathing. The quarterly MDS, dated [DATE], revealed Resident #3 was cognitively intact with no rejection of care recorded. The MDS indicated the resident required extensive assistance for bed mobility and transfer, dressing, toilet use and personal hygiene. The resident was coded as frequently incontinent of urine and bowel with no toilet plan or retraining program attempted. The care plan, reviewed 10/19/16, did not identify Resident #3 refused care and did not identify incontinence or type of bath preferred. Resident #3 was discharged home on[DATE].

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F 0242 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Review of the shower record revealed Resident #3 was documented as receiving 5 showers during her facility stay. The Activity Director (AD) was interviewed on 11/30/16 at 8:33 AM. She stated she had worked with Resident #3 as a NA. The AD stated showers were scheduled twice weekly for residents. If the resident preferred a different schedule, the nurse would be notified and adjustments made if possible. The AD stated Resident #3 enjoyed showers and had no history of refusing care. The Rehabilitation Department Manager (RM) was interviewed on 11/30/16 at 1:36 PM. The RM stated she had evaluated Resident #3 and found her to be alert and oriented. She added while Resident #3 had physical deficits, she had been able to walk with assistance in her room and able to transfer from the chair to the toilet with supervision using a sliding board. The RM added the resident had expressed multiple concerns about toileting and bathing during therapy and she had done a lot of staff training regarding transfer of Resident #3 using the sliding board. The resident had reported staff told her to void in her brief instead of using the toilet. The RM stated due to the resident's severe [MEDICAL CONDITION] and high risk of fractures, she thought staff were fearful to use the sliding board for transfers. The Physical Therapy Assistant (PTA) was interviewed on 11/30/16 at 1:49 PM. The PTA had worked with the resident and described Resident #3 as alert, oriented and able to express her needs. The PTA reported Resident #3 had told therapy staff nursing staff would tell her to void in her brief rather than toilet her. The PTA stated she had filled out several concern forms related to toilet use. She added it was her understanding that prior to Resident #3's discharge home, the toileting issue had been resolved. Nursing Supervisor (NS) #1 was interviewed on 11/30/16 at 2:00 PM. She acknowledged showers scheduled twice weekly for residents, but added that when showers were not given, residents received bed baths. She stated she, along with the other nursing supervisors, were responsible for making sure residents received showers. The NS acknowledged she remembered Resident #3 but was unaware of any problems with her receiving toileting and showers per her preference. The NS acknowledged a staff in-service had been held on showering residents, but could not recall any in-service provided to staff regarding Resident #3's preference for toilet use. On 11/30/16 at 2:12 PM, Nurse #1 was interviewed. The nurse had worked with and remembered Resident #3. She described the resident as alert, oriented, able to express her needs, but at times could be forgetful. The nurse was unaware of any times Resident #3 refused care. She stated at a minimum residents should be offered showers twice weekly and was unaware Resident #3 had only received 5 showers during her facility stay. Nurse #1 added she had been unaware of any toileting issues involving Resident #3. NA #3 was interviewed on 11/30/16 at 2:37 PM. He stated Resident #3 was alert, oriented, could tell staff when she needed to toilet and enjoyed showers. He stated when she had the cast on her leg, Resident #3 used a bed pan. When she became weight bearing, she used a bedside commode. The NA reported the resident had told him she was not being toileting per her preference and was being told to void in her brief, but was unsure what staff had been involved. The NA reviewed the shower sheet for Resident #3 and stated he had no idea why she had received so few showers during her stay in the facility. The Administrator was interviewed on 11/30/16 at 3:05 PM. The Administrator stated staff were assigned to residents to make sure during rounds call bells were in reach, the resident had water and to receive general concerns. The Administrator added the Social Worker (SW) had been assigned to Resident #3; she added the SW was out of the country and not available for interview. The Administrator was unaware staff had instructed Resident #3 to void in her brief rather than toilet her and was unaware she had not received showers per her preference. On review of grievances, the Administrator stated she would try to find the disciplinary action for the NAs or the in-service provided for the NAs related to Resident #3's 8/9/16 grievance, but reported later she was unable to find additional information. Multiple messages were left with the Responsible Party in order to speak with the resident. No return calls were received.
F 0314 **Level of harm** - Actual harm **Residents Affected** - Some	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, physicians, and staff interview, the facility failed to remove wound packing from a sacral pressure ulcer for 1 of 6 residents (Resident #11) investigated for wound care which resulted in the decline of the sacral pressure ulcer and development of an abscess. Findings included: Resident #11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #11's care plan initiated 4/29/16 revealed the resident was care planned for a pressure ulcer on the sacral area. The goal was that the resident's pressure ulcer would decrease in size by next review. The interventions were to measure and record descriptions of the area, location, and size weekly, and to treat the area per physician orders. Review of the resident's quarterly minimum (MDS) data set [DATE] revealed the resident was assessed as having an unstageable pressure ulcer. The measurements of the pressure ulcer were 2.5 centimeters by 2.0 centimeters. Review of a physician's orders [REDACTED]. Record review of the resident's Treatments Administration History for the dates of 7/18/16 - 7/22/16 revealed Resident #11 was documented to have received sacral wound care. According the documentation, the wound was packed with a fine mesh gauze, soaked with normal saline, covered with dry dressing, and secured with tape on 7/18/16, 7/19/16, 7/20/16, and 7/21/16 by Treatment Nurse #1 per physician's orders [REDACTED]. Review of the weekly pressure ulcer documentation dated 7/21/16 at 3:23 PM signed by Treatment Nurse #1 revealed the sacral pressure ulcer was recorded as an unstageable pressure ulcer, 0.8 centimeters by 0.8 centimeters by 0.1 centimeters. Undermining (meaning the wound continued under intact skin) was noted at 12 o'clock 1.5 centimeters, 3 o'clock 0.5 centimeters, 6 o'clock 0.5 centimeters, and 9 o'clock 0.5 centimeters. 100% of the wound bed was documented to be granulation tissue (new healthy tissue growth that occurs during the wound healing process). Pressure ulcer care was documented as performed. Review of a physician's orders [REDACTED]. The order to pack the wound with normal saline soaked fine mesh gauze was discontinued on this date. Review of the weekly pressure ulcer check dated 7/27/16 revealed the wound was documented to be an unstageable pressure ulcer, 0.8 centimeters by 0.8 centimeters by 0.1 centimeters. Undermining was noted at 12 o'clock 1.5 centimeters, 3 o'clock 0.5 centimeters, 6 o'clock 0.5 centimeters, and 9 o'clock 0.5 centimeters. The wound was 100% granulation tissue. Review of the weekly pressure ulcer check dated 8/4/16 revealed the wound was documented to be an unstageable pressure ulcer, 1.0 centimeters by 1.0 centimeters with no depth. Undermining was noted at 12 o'clock 1.0 centimeters, 3 o'clock 2.0 centimeters, 6 o'clock 1.0 centimeters, and 9 o'clock 0.5 centimeters. The wound was 100% granulation tissue. Review of a wound care physician's consult note dated 8/11/16 revealed the resident was assessed at a doctor's office by Physician #1. Physician #1 discussed options with the family for continued treatment. The order for the [MEDICATION NAME] dressing was continued as a result of the consult. Review of the resident's quarterly minimum (MDS) data set [DATE] revealed the resident was assessed as having an unstageable pressure ulcer. The measurements of the pressure ulcer were 1.5 centimeters by 1.5 centimeters with no depth. Review of the weekly pressure ulcer check dated 8/19/16 revealed the wound was documented to be an unstageable pressure ulcer, 0.5 centimeters by 0.5 centimeters with no depth. The wound was 100% granulation tissue. Review of the weekly pressure ulcer check dated 8/25/16 revealed the wound was documented to be an unstageable pressure ulcer, 0.3 centimeters by 0.3 centimeters with no depth. The wound was 100% granulation tissue. Review of the weekly pressure ulcer check dated 8/29/16 revealed the wound was documented to be an unstageable pressure ulcer, 0.5 centimeters by 0.5 centimeters with no depth. The wound was 100% [MEDICATION NAME] tissue. Review of the weekly pressure ulcer check dated 9/5/16 revealed the wound was documented to be a stage II pressure ulcer, 0.3 centimeters by 0.3 centimeters with no depth. The wound was 100% [MEDICATION NAME] tissue. Review of the weekly pressure ulcer check dated 9/13/16 revealed the wound was documented to be a stage II pressure ulcer, 0.2 centimeters by 0.2 centimeters with no depth. The wound was 100% [MEDICATION NAME] tissue. Review of the weekly pressure ulcer check dated 9/26/16 revealed the wound was documented to be a stage I pressure ulcer, 0.5 centimeters by 0.5 centimeters with no depth. The wound was 100% [MEDICATION NAME] tissue.

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F 0314 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 3) Review of Resident #11's progress note dated 10/5/16 revealed during the routine dressing change to sacral pressure ulcer, Treatment Nurse #2 noted a large 6 centimeters by 6 centimeters soft fluid-filled packet at the wound. The skin color at the wound was noted to be red. Treatment Nurse #2 notified the Medical Director and an appointment was scheduled with Physician #1 the next day. Review of a wound care physician's consult note dated 10/6/16 revealed Physician #1 assessed Resident #11's pressure ulcer at his doctor's office. The assessment revealed the sacral ulcer had increased pain and redness. A large abscess was noted to be 12 centimeters by 12 centimeters by 5 centimeters on the resident's sacrum. Physician #1 performed an incision and drainage of the abscess and discovered 6 inches of fine mesh gauze in the subcutaneous tissue. Review of Resident #11's most recent Minimum (MDS) data set [DATE] revealed the resident had a stage III pressure ulcer. Review of Resident #11's most recent weekly pressure ulcer check dated 11/28/16 revealed the resident's sacral pressure ulcer measurements were 2.5 centimeters by 1.5 centimeters by 0.7 centimeters. Review of the resident's active [DIAGNOSES REDACTED]. During a telephone interview on 11/30/16 at 12:20 PM, Physician #1 stated when he observed Resident #11 on 8/11/16 he did not observe any fine mesh gauze in the wound. He further stated he only continued the ordered [MEDICATION NAME] dressing following this visit. Physician #1 stated that the facility placed a fine mesh gauze in the pressure ulcer on the sacrum intentionally or unintentionally at some point while the wound was still open. He further stated the gauze was either lost or forgotten about and the wound healed over the gauze. Physician #1 further stated that he had no doubt the gauze was the cause of the abscess that Resident #11 developed and he treated on 10/6/16. Physician #1 stated that someone in the facility's staff had made a mistake and either not followed the order correctly or had lost a gauze in the wound somehow. He further stated that the fine mesh gauze should not have been left in the wound. During an interview on 11/30/16 at 2:45 PM Treatment Nurse #2 stated Resident #11's sacral pressure ulcer was first identified on 4/27/16. Treatment Nurse #2 stated that she was not the wound care nurse at that time. She stated that when she began care of Resident #11's sacral pressure ulcer, the skin was healing and intact. She stated that the wound care orders at that time were for [MEDICATION NAME] dressing changed every three days and as needed. She further stated she had never packed the wound prior to it being reopened 10/6/16. Treatment Nurse #2 stated that she felt the resident had progressed well and she believed care was about to be discontinued, but on 10/5/16 she changed the resident's dressing and observed a fluid pack around the wound. She stated she alerted the medical director and the resident was sent to Physician #1's office the next day for wound care. She added a piece of wound packing in the resident's pressure ulcer was found by Physician #1. She further stated that when she placed fine mesh gauze in a wound no more than one continuous length of fine gauze should be placed and there should be enough fine mesh gauze in the wound to be observed and taken hold of to be removed. Treatment Nurse #2 stated that when changing a [MEDICATION NAME] dressing, she would inspect the wound for healing and make measurements. She further stated that when she began to care for the resident's wound full time, the wound had already closed and the skin was intact so she was unable to inspect inside the wound. During observation on 11/30/16 at 2:52 Treatment Nurse #2 provided wound care to Resident #11's sacral pressure ulcer. The resident's wound was observed to have an opening approximately 2.0 centimeters by 1.5 centimeters by 0.7 centimeters with 3 centimeters of undermining from 1 o'clock to 7 o'clock. The wound care nurse provided wound care according to the physician's order [REDACTED]. During an interview on 11/30/16 at 5:22 PM the Director of Nursing (DON) stated it was her expectation that wound care with nu-gauze be provided according to the doctor's orders. She further stated that she expected the wound would be inspected by the wound care nurse upon return to the facility from the doctor's visit with new orders. She further stated her expectation was anything noted foreign or unusual in the wound during the assessment to be documented and reported. The Director of Nursing stated the nurses informed her of the abscess found on 10/6/16. The DON stated she believed the abscess could have caused harm to the resident, but did not know if the abscess was a result of the gauze being left in the resident. During an interview on 11/30/16 on 5:57 PM Treatment Nurse #2 stated that after the abscess had been found on 10/6/16 she reported it to the charge nurse and the DON. She stated she covered the Treatment Nurse #1's shift on 7/15/16 and then again on 7/23/16. During these dates the [MEDICATION NAME] dressing was ordered. She stated she did not remember ever placing fine mesh gauze in the resident's wound and that she checked the dressing each day and performed the weekly wound assessments as ordered. She further stated that due to the abscess Resident #11 had developed, the resident had increased reports of pain to the area. She stated that the resident was receiving pain medications for the increased pain. Treatment Nurse #1 no longer worked for the facility. Attempts were made to interview Treatment Nurse #1 with no return calls received.
F 0431 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.** Based on observations, staff interviews and record review the facility failed to secure bottles of medication in 1 of 3 medication carts (medication cart #1) and failed to secure insulin in a locked cart for 1 of 1 diabetic carts (diabetic cart #1) observed during medication pass. Findings included: The facility policy, titled, Storage of Medications , revised September 2003, revealed: · Compartments containing medications are locked when not in use. Trays or carts used to transport such items are not left unattended. Compartments include, but are not limited to, drawers, cabinets, rooms, refrigerators, carts and boxes. On 11/29/16 at 8:53 AM, a medication cart attended by Nurse #3 was observed with the nurse not within visual range of the cart. On top of the medication cart #1 was an unlabeled clear cup with a purple liquid, a bottle of Aspirin, a bottle of Folic Acid, a bottle of Senna, a bottle of Colace, a bottle of multivitamin and a bottle of Miralax. Next to medication cart #1, was an unlocked cart with tape that identified the cart as the Diabetic Cart . Diabetic cart #1 was observed to be unlocked. The top drawer of the diabetic cart was noticed to be unlocked. Nurse #3 returned from a room approximately 3 doors down from where the medication cart and the diabetic cart were parked in the hall at 8:57 AM. She stated she had been taught to keep all medications securely locked. She added she had forgotten to put the medications away before going into the resident ' s room to give the resident their morning medications and had forgotten to lock the diabetic cart. The nurse opened the diabetic cart and confirmed there were open vials of insulin, insulin pens and syringes in diabetic cart #1. The Director of Nursing (DON) was interviewed on 11/29/16 at 3:58 PM. She stated medications should be stored in a locked cabinet at all times. The DON added there was always the risk of the nurse being called away during an emergency or dementia residents passing the cart could take the medications. The DON stated there was not an appropriate time for medications to be left on top of the cart. She added medications should not be placed in clear cups without identifying information