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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345264	A. BUILDING ______ B. WING ______	C 10/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEY TOTAL LIVING CENTER	514 OLD MOUNT HOLLY ROAD STANLEY, NC 28164

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F 000	INITIAL COMMENTS No deficiency cited as result of CI survey Event ID # 3V6G11.	F 000	Preparation and submission of this written plan of correction does not constitute an agreement of admission by Stanley Total Living Center of the truth to the facts alleged or conclusions set forth in the CMS-2567. This Plan of Correction is written in response to the Statement of Deficiencies and demonstrates our good faith and desire to improve quality care and services rendered to our residents—it is submitted as required by Federal and State law.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow bowel protocol management and medication monitoring for 1 of 10 sampled residents reviewed for medication management. (Resident #49). The findings are: Review of an undated facility bowel management procedure specified the unit ward clerks will print on a daily basis the NO BM (bowel movement) in 3 day report and give to the floor nurse for initiation of the bowel protocol. The Staff Development Coordinator/Assistant Director of Nurses was responsible for checking daily the compliance of staff for initiation of the bowel protocol and report noncompliance to the Director of Nurses (DON) for further investigation. Resident #49 was admitted to the facility 09/06/12 with diagnoses including constipation.	F 309	Resident #49 was assessed to ensure no current concerns related to bowel movements or lack thereof. An MD order was also initiated for Dulcolax suppository every 3rd day for constipation. A 100% audit of facility residents was conducted to ensure compliance—any resident found not to have had a bowel movement in the last 48 hours had the bowel movement protocol initiated at that time.	11/1/12 11/1/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] RN
TITLE: Administrator
(X6) DATE: 11/8/12

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 309	Continued From page 1 Facility physician standing orders dated 09/06/12 included orders for constipation. The instructions specified to initiate the orders after 48 hours of no documented bowel movements. The order stated all steps must be followed accordingly. The steps included liquid laxative 30 milliliters (ml) by mouth. If no BM after 8 hours administer laxative suppository 10 milligrams (mg) rectally. If no BM after 1 hour administer 1 enema rectally. If no BM after 30 minutes administer Magnesium Citrate 240 ml bottle by mouth. If no BM after 2 hours, contact the physician for further directions. The admission Minimum Data Set (MDS) dated 09/13/12 indicated Resident #49 demonstrated severe impairment of cognition, and required extensive assistance with toileting, and was occasionally incontinent of bowel. A care plan dated 09/21/12 specified Resident #49 was at risk for constipation due to decreased mobility and a history of constipation. The care plan goal was for the resident to have a regular bowel movement pattern. Care plan approaches included monitor bowel patterns to make sure resident has a bowel movement at least every 3 days and administer medications per physician's orders. A review of a Bowel and Bladder Detail Report dated 09/07/12 through 10/23/12 revealed 3 periods of 5 days each that no bowel movement was recorded. The dates involved were 09/08/12 through 09/12/12, 09/30/12 through 10/04/12, and 10/12/12 through 10/16/12. A review of the September 2012 and October	F 309	No change to the bowel movement protocol itself was necessary; however the system for the maintenance and follow through of this program was revised: The Nurse In Charge will review the No Bowel Movement Report daily for the last (6) shifts and forward to the 1st shift staff nurse for initiation of the bowel protocol. This staff nurse will document ON the report what was done (and if successful) and will follow-up with the Nurse In Charge for compliance. If still no bowel movement, the 2nd shift staff nurse will continue the bowel protocol as ordered and will document this on the sheet (as well as any results). This will continue following the bowel protocol orders through the 3rd shift until the resident has a bowel movement. The Nurse In Charge will review the report after 24 hours to audit the process for completion and ensure the resident has in fact had a documented bowel movement. This report will be forwarded to the ADON for further evaluation– noncompliance with the protocol as written will be forwarded to the DON for disciplinary action as necessary. Nursing staff were in-serviced on this policy and procedures for the bowel protocol on 11/1/12 by the Director of Nursing.	11/1/12

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F 309	Continued From page 2 2012 Medication Administration Records revealed a liquid laxative was administered 09/11/12, 09/12/12, 09/14/12, 10/15/12, and 10/17/12. No documentation of laxative suppositories, enemas, or bowel assessments was found. No medications were administerd during the 09/30/12 through 10/04/12 time period. An interview on 10/23/12 at 2:31 PM with Nurse #3 revealed she initiated the bowel protocol on 10/12/12 and administered a liquid laxative. Nurse #3 stated when a standing order was initiated in the computer, it was treated as a one time order and disappeared from view within 24 hours. She added she was unable to see the liquid laxative had been utilized the day before. Nurse #3 explained the procedure for the facility bowel protocol as it was stated in the facility bowel management procedure. An interview on 10/24/12 at 3:15 PM was conducted with the DON. She stated her expectation was that the facility bowel management procedure was followed. The DON acknowledged the procedure was not followed with Resident #49.	F 309	Random weekly audits will be conducted by the ADON, SDC, or other designee of 10 residents to ensure compliance with the facility bowel movement protocol x 4 weeks, then monthly X 3, and then quarterly x 3. Results of these audits will be reported in the quarterly QA&A meeting. The QA&A Committee will make changes as necessary to the plan of correction to ensure continued compliance.	11/9/12
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration, or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329	Resident #139 had a Vitamin D level drawn immediately and obtained STAT—the results were within normal limits and the physician did not make any changes to the medication regimen.	10/25/12

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F 329	Continued From page 3 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to collect a laboratory test to determine medication regimen efficacy as ordered for 1 of 11 residents (Resident #139). The findings are. Resident #139 was admitted to the facility 06/15/12 with diagnoses including atrial fibrillation, hypocalcemia and vitamin D deficiency. A review of Resident #139's medical record revealed a physician assistant's (PA) note dated 06/28/12 documenting the resident's assessment of vitamin D deficiency and a plan to administer to the resident vitamin D at a dose of 50,000 units each week for 12 weeks; upon completion of the treatment regimen, a blood specimen collection	F 329	A 100% audit of facility residents was conducted to ensure that no labs were missed within the last week—none were noted. The lab protocol was revised as follows: The nurse receives a lab order and places this in the lab computer to generate a lab slip. Thenurse will initial in the upper right corner of the lab order that it has been processed and will note this in the Lab Book. The Nurse In Charge will audit the pink copies of physician's orders daily—she will initial in the upper right corner noting this 2nd check and will verify that a lab slip has in fact been generated and the lab is logged in the Lab book. All pink copies of physician's orders will then be forwarded to the ADON for final review—he will place his initials in the top right corner of all lab orders as the 3rd check. Nursing staff were in-serviced on this policy and procedures for processing lab orders on 11/1/12 by the Director of Nursing.	11/1/12 11/1/12

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F 329	Continued From page 4 for vitamin D level laboratory testing would occur to determine treatment efficacy. A review of Physician Assistant (PA) orders dated 06/29/12 revealed the order to start vitamin D supplementation as described in the note and for blood specimen collection for vitamin D level laboratory testing upon completion of the 12 week supplementation regimen. A review of laboratory results in the medical record from 06/29/12 through 10/25/12 revealed no results of a vitamin D level. On 10/25/12 at 9:30 AM Nurse #1 was interviewed and after reviewing the order for a vitamin D level stated that this laboratory test would have been due at the end of September, 2012. Nurse #1 stated she would check on the status of this order. On 10/25/12 at 9:38 AM Nurse #1 was interviewed and stated that based on a review of laboratory orders in a laboratory computer located at the 100 unit nursing station, the order written on 06/29/12 for a vitamin D level was never entered into the computer so that at the end of September, 2012 Resident #139's blood specimen could be collected. Nurse #1 stated that prior to the interview she entered the order into the laboratory computer, generated a laboratory requisition and printed labels for a blood specimen tube for immediate collection. On 10/25/12 at 2:25 PM Nurse #2 was interviewed and stated that when a laboratory test is ordered, it is entered into the laboratory computer; when the laboratory test is due it will print out a requisition for the day the laboratory specimen is to be collected.	F 329	Random weekly audits will be conducted by the ADON of 10 residents to ensure compliance with the facility lab order protocol x 4 weeks, then monthly X 3, and then quarterly x 3. Results of these audits will be reported in the quarterly QA&A meeting. The QA&A Committee will make changes as necessary to the plan of correction to ensure continued compliance.	11/9/12

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F 329	Continued From page 5 On 10/25/12 at 3:30 PM the Director of Nursing (DON) was interviewed. The DON stated her expectation that the nurse who received the order from the provider is responsible to enter the laboratory test order into the laboratory computer. The DON stated that the nurse who received the order on 06/29/12 is no longer employed by the facility.	F 329		