| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345477 | A. BUILDING _____ B. WING _____ | C 05/31/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE OAKS AT SWEETEN CREEK | 3864 SWEETEN CREEK RD ARDEN, NC 28704 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, physician interview and staff interviews the facility failed to prevent a delay in transport to the hospital of a resident with rectal bleeding and failed to assess a resident after an unknown injury to the head in 2 of 5 sampled residents. (Residents #1 and #5).<br><br>The findings included:<br><br>1. Resident #1 was admitted to the facility on 04/30/13 with diagnoses which included abdominal pain, peritonitis (inflammation of the lining of the stomach), a ruptured stomach ulcer and a history of colon cancer.<br><br>The admission (5-day) Minimum Data Set (MDS) dated 05/07/13 indicated Resident #1 had problems with short term and long term memory and was severely impaired in cognition for daily decision making. The MDS further indicated Resident #1 was always incontinent of bowel and required extensive assistance by staff for toileting and personal hygiene.<br><br>A review of admission physician's orders dated | F 309 | 1. Resident #1was seen by the physician on 6/21/2013; new orders were received. Resident #5 no longer resides at the facility.<br>Nurse #1 was in-serviced by the Assistant Director of Clinical Services (ADCS) on 5/31/13 on timely transfers based on resident medical needs.<br>Nurse #2 was in-serviced by the ADCS on 5/31/13 on timely transfers based on resident medical needs.<br>Nurse #3 was in-serviced by the Director of Clinical Services (DCS) on 5/31/13 on timely transfers based on resident medical needs.<br>The two nurses associated with assessing resident #1 were in-serviced by the DCS on 5/31/13 on completing accurate post-incident assessments as well as correct notifications regarding changes of condition.<br>The nurse who failed to fully assess and failed to properly notify regarding an unknown head injury in the case of resident #5 was individually in-serviced by the DCS on 6/27/2013 regarding assessments for changes in condition, including unknown head injuries, as well as the procedure for notifications.<br>2. All residents have the potential to be affected. On 06-27-2013 the DCS/Nurse Manager reviewed current facility residents to ensure that they were not experiencing a change in condition or were status post a resident incident requiring notification to the resident's physician for further orders to include but not be limited to a transfer to a higher level of care. DCS/Nurse Manager immediately notified the resident's physician of any noted discrepancies. | 7/1/2013 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: B Welch | TITLE: Administrator | (X6) DATE: 6/27/13

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.

ORIGINAL SIGNATURE DATE: 6-21-13

NC DHSR Black Mountain WRO Received JUN 27 2013 by: SKH

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| F 309 | Continued From page 1<br>04/30/13 indicated in part:<br>Aspirin 81 milligrams by mouth daily<br>Heparin 5,000 units subcutaneously every 8 hours<br><br>A review of a care plan dated 05/01/12 revealed a problem statement that Resident #1 was at risk for bleeding due to anticoagulant (heparin) therapy.<br><br>A review of a physician order dated 05/20/13 at 11:14 PM indicated to transfer Resident #1 to the hospital emergency room for evaluation and treatment of rectal bleeding.<br><br>A review of nurse's notes dated 05/20/13 at 10:40 AM revealed Resident #1 had no so signs and symptoms of distress and there was no documentation regarding rectal bleeding during the 7:00 AM to 3:00 PM shift.<br><br>A review of nurse's notes dated 05/20/13 at 7:30 PM indicated Resident #1 remained on heparin therapy. The notes further indicated there was no new bruising or active bleeding noted.<br><br>A review of a resident vital sign chart revealed on 05/20/13 Resident #1's temperature was 98 degrees Fahrenheit, blood pressure 120/62, pulse 63 and respiration's 20. There was no time documented for these vital signs.<br><br>A review of a facility document titled "SBAR" (Situation, Background, Assessment/Appearance, Request) form dated 05/20/13 indicated Resident #1 had rectal bleeding that started on the 7:00 AM to 3:00 PM shift. The notes further indicated rectal bleeding | F 309 | 3. Licensed Nurses were in-serviced by the ADCS on 6/17/2013-6/23/2013 with regard to completing an assessment in the event of a change in condition or resident incident, notification of the physician for further orders, timely implementation of physician's orders, notification of the resident's Responsible Party (RP), and documentation of the nursing assessment and chain of events in the resident's medical record.<br>4. The DCS/ Nurse Manager will conduct Quality Improvement (QI) monitoring of residents requiring a transfer to a higher level of care or status post a resident incident to ensure the nurse assessed the resident, notified the physician for further orders, implemented the orders in a timely manner, notified the resident's RP, and documented the **nursing assessment** and chain of events in the resident's medical record. QI monitoring will be done 5 times a week for 4 weeks, 3 times a week for 4 weeks, 1 time a week for 4 weeks, and then 1 time monthly for 3 months, using a sample size of 3. The DCS/Nurse Manager will report findings of QI monitoring to the Quality Assurance /Performance Improvement Committee monthly x 6 months for continued substantial compliance and/or revision. | |

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| F 309 | Continued From page 2<br>continued during the 3:00 PM - 11:00 PM shift with small blood clots. The notes revealed an oxygen saturation percentage of 92 percent but there were no vital signs documented in these notes. A section labeled progress note indicated Resident #1 started bleeding rectally on the 7:00 AM to 3:00 PM shift and continued with a small amount of rectal bleeding with small clots. The notes revealed Resident #1 had a small soft bowel movement earlier with moderate bleeding with small clots and a physician order was obtained to send Resident #1 to the hospital emergency room for evaluation.<br>The notes further indicated a time line on 5/20/13 as follows:<br>11:50 PM Resident #1's responsible party was notified<br>11:50 PM Emergency Medical Services (EMS) was called for transport<br>12:10 AM EMS arrived<br>12:17 AM Resident #1 left the facility with EMS<br><br>A review of a resident transfer form dated 5/20/13 indicated the reason for Resident #1's transfer was rectal bleeding and was on heparin therapy three times a day.<br><br>During an interview on 05/30/13 at 1:45 PM Nurse #1 stated he worked the 7:00 AM to 3:00 PM shift and was giving change of shift report on 05/20/12 to the 3:00 PM to 11:00 PM nurse when a nurse aide reported to them that Resident #1 had blood in his bowel movement. Nurse #1 stated after he finished report he went with the 3:00 PM to 11:00 PM nurse to Resident #1's room and Resident #1 had a brown, dark red bowel movement. He stated he told the 3:00 PM to 11:00 PM nurse to monitor Resident #1 and | F 309 | | |

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| F 309 | Continued From page 3 | F 309 | | |

verified that he did not document any nurse's notes because he was finished with his shift. He further explained Resident #1 had not had any rectal bleeding during his shift on 05/20/13.

During an interview on 05/30/13 at 3:23 PM Nurse #2 stated she received the shift report on 05/20/13 from Nurse #1 when a nurse aide came to them and reported Resident #1 had some rectal bleeding. She explained they went to Resident #1's room and he had a soft bowel movement with a small amount of red bleeding. She stated the nurse aide cleaned and changed Resident #1 and they checked on him throughout the evening. She further stated at approximately 10:30 PM a nurse aide told her that Resident #1 was having some rectal bleeding. She explained she went to Resident #1's room and he had bright red bleeding with a few small clots. She stated she called the nursing administrator on call because she wanted to send Resident #1 to the hospital because he was bleeding and was on heparin. Nurse #2 stated she was getting Resident #1's transfer paperwork together when the 11:00 PM to 7:00 AM nurse arrived and she gave him a shift report and counted narcotics and the 11:00 PM to 7:00 AM nurse told her that he would take care of sending Resident #1 to the hospital but she did not know exactly what time Resident #1 left to go to the hospital.

During an interview on 05/30/13 at 4:31 PM Nurse Aide (NA) #1 stated she worked the 3:00 PM to 11:00 PM shift on 05/20/13 and provided care to Resident #1. She stated she had been told in shift report at 3:00 PM on 05/20/13 that Resident #1 had rectal bleeding and when she checked Resident #1 during her first round he

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| F 309 | Continued From page 4<br>had a small bowel movement with a small amount of bleeding that was dark red in color. She explained she checked and changed Resident #1 again after 6:00 PM because he was wet but did not remember if he had any rectal bleeding. NA #1 further explained she was making her last rounds between 9:30 PM and 10:30 PM and checked Resident #1 and he was having rectal bleeding with blood clots. She stated she went and told Nurse #2 and showed her the brief she had removed from Resident #1 that contained bright red blood with blood clots and blood had leaked out on the bed.<br><br>During a telephone call on 05/30/13 at 9:07 PM Nurse #3 stated he worked the 11:00 PM to 7:00 AM shift on 05/20/13 and got a shift report and counted narcotics with Nurse #2. He further stated he was told that Resident #1 had rectal bleeding and needed to be sent to the hospital for evaluation. He explained it was about 10 minutes till midnight when the call was made to EMS for transport of the resident to the hospital and they took Resident #1's blood pressure about the time EMS was called and remembered his vital signs were normal. He further explained when EMS arrived; he took them to Resident #1's room and assisted with transferring Resident #1 to the stretcher and Resident #1 complained of abdominal pain when they moved him. Nurse #3 stated there was a delay in sending Resident #1 to the hospital because they were trying to get all of the transfer paperwork together. He stated he thought Resident #1 was stable but could have gone bad and Resident #1 should have been sent to the hospital earlier.<br><br>During an interview on 05/31/13 at 8:26 AM the | F 309 | | |

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| F 309 | Continued From page 5<br>Medical Director stated there should not have been a delay in transporting Resident #1 to the hospital on 05/20/13 due to his medical history with abdominal bleeding. He explained he considered that bleeding was similar to chest pain because you didn't know what might happen. He further explained it was his expectation that Resident #1 should have been transported to the hospital as soon as possible after the rectal bleeding started.<br><br>During an interview on 5/31/13 at 12:11 PM the Assistant Director of Clinical Services stated she received a call from Nurse #2 on 05/20/13 between 10:35 PM - 10:40 PM. She explained Nurse #2 told her Resident #1 was having rectal bleeding and wanted to send him to the hospital because he was on heparin and she told Nurse #2 to send him. She stated when she returned to work the next morning she saw Resident #1's name was still on the daily census and found out Resident #1 was not transported to the hospital until after midnight. She stated Resident #1's transfer should not have been delayed and it was her expectation when nursing staff had orders to transfer a resident to the hospital there should not be a delay in sending them out.<br><br>During an interview on 05/31/13 at 1:16 PM the Director of Nursing (DON) stated it was her expectation when nursing administration told nursing staff to send a resident to the hospital they should stop what they were doing and send the resident out. She further stated she expected nursing staff to assess the resident and document their assessment and vital signs in the nurse's notes. | F 309 | | |

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| F 309 | Continued From page 6<br><br>2. Resident #5 was admitted to the facility 03/15/13 after hospitalization 03/5/13-03/15/13 with new onset of seizure activity. Admitting diagnoses also included traumatic brain injury, failure to thrive, muscle weakness, anxiety, encephalopathy, convulsion, post traumatic stress disorder and liver disease.<br><br>Review of the medical record of Resident #5 included a nurses note dated 05/12/13: 4:15 AM Received 7.5 milligrams of Morphine Sulfate at 1:00 AM for complaint of headache. Resident said she hit her head on the door. Noticed a slight bump on left forehead with a slight redness approximately 1/4" in length.<br><br>Review of subsequent nurses notes through time of discharge on 05/16/13 revealed there was no indication the physician had been notified or further assessments related to a potential head injury had been implemented.<br><br>On 05/31/13 at 10:10 AM the Director of Nursing (DON) stated when there is evidence of injury the following should be implemented:<br>1. Complete a SBAR (Situation, Background, Assessment/Appearance, Request) form which is used to address concerns.<br>2. Notify the residents physician and responsible party.<br>3. Notify the DON of any incidents with injury<br>4. Document in the facility computer system for quality assurance review<br>5. Initiate root cause analysis<br>6. Place on the nurses 24 hour report so subsequent nursing shifts can be aware of any resident concerns or needs. | F 309 | | |

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| F 309 | Continued From page 7<br>The DON stated she was not aware Resident #5 had hit her head on 05/12/13 because a SBAR was not done, notification had not been made of the injury to the DON, documentation was not done in the facility computer system and root cause analysis had not been initiated. The DON stated nurses 24 hour reports are only kept for a two week time frame so it was not known if this had been documented on the 24 hour report. The DON stated because these forms had not been completed management staff did not review the circumstances of the incident to put measures in place to prevent future incidents. The DON stated she would have expected neuro checks to have been initiated on 05/12/13 since the injury involved the resident's head. The DON provided a copy of the Neurological Assessment Flow Sheet and stated she would have expected this form to be implemented on Resident #5 after the 5/12/13 injury to her head.<br><br>On 05/31/13 at 11:25 AM the nurse that wrote the note on 05/12/13 stated the best she could recall she monitored Resident #5 after noting the head injury to make sure she wasn't drowsy and that she didn't have any signs/symptoms of seizure activity. The nurse stated she most likely would have passed on the concern to the oncoming nurse so she could keep an eye on the resident. The nurse stated she would only have done neuro checks if Resident #5 started vomiting. The nurse stated she could not explain why she did not complete the SBAR, notify the DON, document the incident in the facility computer or initiate root cause analysis. The nurse stated she could not recall if she noted the incident on the nurses 24 hour report. | F 309 | | |

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| F 309 | Continued From page 8<br>On 05/31/13 at 12:10 PM the nurse that worked 05/12/13 from 7:00 AM-7:00 PM reviewed nursing documentation written during her shift. The nurse stated she could not recall if the 05/12/13 injury to the head of Resident #5 had been reported to her. The nurse stated if it had been it was her usual practice to write in a nurses note anything in particular she was monitoring, including neuro checks. The nurse verified neuro checks had not been done during her shift. | F 309 | | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>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.<br><br>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. | F 329 | | |

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| F 329 | Continued From page 9<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interviews the facility failed to obtain a Depakote level as ordered by the physician for 1 of 3 sampled residents.<br><br>The findings are:<br><br>Resident #5 was admitted to the facility 03/15/13 after hospitalization 03/5/13-03/15/13 with new onset of seizure activity. Admitting diagnoses also included traumatic brain injury, failure to thrive, muscle weakness, anxiety, encephalopathy, convulsion, post traumatic stress disorder and liver disease.<br><br>Medications ordered for Resident #5 included Depakote and Vimpat. These medications had been initiated during the 03/5/13-03/15/13 hospitalization secondary to the onset of seizure activity.<br><br>Although the care plan for Resident #5 did not address seizures an update on 03/29/13 noted, "Depakote for seizure".<br><br>A note by the family nurse practitioner on 03/21/13 included, "She is in need of a Depakote level which will be drawn Tuesday". On 04/02/13 a physician's order was written for Depakote level on Thursday. Review of the medical record revealed the Depakote level was not done as ordered.<br><br>Resident #5 was followed by a psychiatrist and a note on 04/10/13 addressed, "a follow-up | F 329 | 1. Resident #5 no longer resides at the facility.<br>2. Residents who receive lab orders have the potential to be affected by this citation. A review of current residents' lab orders for the past 60 days was conducted by the DCS/Nurse Manager on 6/24/13-6/30/13 to ensure that lab orders were logged on the scheduled due date in the lab book, completed as ordered and the physician was notified of results. DCS/Nurse Manager notified the resident's physician of any discrepancies for further orders.<br>3. Licensed Nurses were in-serviced by the ADCS on 6/17/2013-6/23/2013 with regard to processing lab orders to include logging lab orders in the lab book on the scheduled due date, completion of the labs as ordered and notification to the physician of lab results. A second check system was put in place to include the review of new lab orders in Morning Interdisciplinary Team Meeting on Monday through Friday by the DCS/Nurse Manager. DCS/Nurse Manager will then verify that the orders were properly logged on the scheduled due date, completed as ordered and the physician was notified of the results.<br>4. The DCS/Nurse Manager will conduct QI monitoring of new lab orders for correct processing to include: logging on the scheduled due date in the lab book, completion as ordered, and notification to the physician of lab results 5 times a week for 4 weeks, 3 times a week for 4 weeks, 1 time a week for 4 weeks, and then 1 x monthly for 3 months, using a sample size of 5. | 7/1/2013 |

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| F 329 | Continued From page 10<br>Depakote level is pending."<br><br>The medical record of Resident #5 was reviewed by the consultant pharmacist on 04/04/13 and 05/02/13 and these notes did not address the 04/02/13 order for a Depakote level.<br><br>Review of nurses notes revealed on 05/04/13 at 5:55 PM, "Resident was sitting in dining room with family when the nurse was called in because resident was having seizure like activity. Hands and feet shaking and resident repeating 'Cheryl'. Answered questions appropriately when asked. (Name of physician) notified. Nursing order received for Ativan .5 milligram, one dose. Dose given and resident assisted to bed. Resting quietly no more shaking, seizure activity noted.<br><br>On 05/30/13 at 4:00 PM the Director of Nursing (DON) verified the Depakote level had not been completed as ordered on 04/02/13. The DON stated the facility policy was for the nurse that took the order to write it in the lab book the day that it was due. The DON stated she did not see the order for Depakote in the lab book and that it should have been drawn on 04/04/13. The DON stated because there was not a second check of physician orders it was not identified as not completed.<br><br>On 5/31/13 at 8:25 AM the physician of Resident #5 stated his expectation was for lab orders to be done as ordered.<br><br>The nurse that wrote the 04/02/13 order was interviewed on 05/31/13 at 8:30 AM. The nurse stated she could not explain what happened. The nurse stated she was aware the facility policy was | F 329 | The DCS/Nurse Manager will report the findings of QI monitoring to the QA/PI Committee monthly x 6 months for continued substantial compliance and/ or revision. | |

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| F 329 | Continued From page 11<br>to write lab needs in the lab book. The nurse looked through the lab book and verified the order to check the Depakote level had not been placed in the book which was why it was not done.<br><br>On 05/31/13 at 8:45 AM the DON reviewed the consultant pharmacist recommendations for April and May and stated there was nothing regarding the Depakote level for Resident #5. The DON stated she expected lab work to be completed as ordered and was not aware the Depakote level was not done as ordered for Resident #5 until brought to her attention. | F 329 | | |
| F 514 SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and staff interviews the facility failed to complete nursing assessment documents for a resident with rectal bleeding. (Resident #1). | F 514 | | |

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| F 514 | Continued From page 12<br>The findings included:<br><br>Resident #1 was admitted to the facility on 04/30/13 with diagnoses which included abdominal pain, inflammation of the lining of the stomach, a ruptured stomach ulcer and a history of colon cancer.<br><br>The admission (5-day) Minimum Data Set (MDS) dated 05/07/13 indicated Resident #1 had problems with short term and long term memory and was severely impaired in cognition for daily decision making. The MDS further indicated Resident #1 was always incontinent of bowel and required extensive assistance by staff for toileting and personal hygiene.<br><br>A review of a vital signs chart revealed on 05/20/13 Resident #1's temperature was 98 degrees Fahrenheit, blood pressure 120/62, pulse 63 and respiration's 20. There was no time documented for these vital signs.<br>A review of a facility document titled "SBAR" (Situation, Background, Assessment/Appearance, Request) form dated 05/20/13 indicated:<br>S: Situation: Rectal Bleeding that started on 7:00 AM -3:00 PM shift. The bleeding continued on 3:00 PM - 11:00 PM shift with small clots.<br>B: Background: Resident is at the nursing home for rehabilitation.<br>Pulse Oximetry 92 percent.<br>Allergies: No Known Allergies<br>A: Assessment (RN) or appearance (LPN): No notes documented.<br>R: Request: No notes documented.<br>There was no staff name, date or time on the signature lines at the bottom of the form but | F 514 | 1. Resident #1 was seen by the physician on 6/21/2013; new orders were received. Nurse #2 was in-serviced by the ADCS on 5/31/13 on documenting a nursing assessment on a resident with a change in medical condition.<br>Nurse #3 was in-serviced by the DCS on 5/31/13 on documenting a nursing assessment on a resident with a change in medical condition.<br>2. All residents have the potential to be affected. On 06-27-2013 the DCS/Nurse Manager reviewed current residents to ensure that they were not experiencing a change in condition and/ or were not status post a resident incident that would require a nursing assessment and/or transfer to a higher level of care. DCS/Nurse Manager immediately completed a nursing assessment on current residents with any noted discrepancies and then immediately notified the physician for further orders to be implemented by the nurse, to include but not be limited to timely transfer to a higher level of care. DCS/Nurse Manager then documented the nursing assessment in the medical record along with the chain of events.<br>3. Licensed Nurses were in-serviced 6/17/2013-6/23/2013 by the ADCS on completing a nursing assessment on a resident experiencing a change in condition and/or status post a resident incident, notification of the physician for further orders, timely transfer to a higher level of care as applicable, notification of the RP, and documentation of the nursing assessment and chain of events in the resident's medical record. | 7/1/2013 |

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| F 514 | Continued From page 13<br>Resident #1's name was documented.<br>A section labeled progress note indicated Resident #1 started bleeding rectally on the 7:00 AM to 3:00 PM shift and continued with a small amount of rectal bleeding with small clots. The notes revealed Resident #1 had a small soft bowel movement earlier with moderate bleeding with small clots and a physician order was obtained to send Resident #1 to the hospital emergency room for evaluation.<br>The notes further indicated a time line on 5/20/13 as follows:<br>11:50 PM Resident #1's responsible party was notified<br>11:50 PM Emergency Medical Services (EMS) was called for transport<br>12:10 AM EMS arrived<br>12:17 AM Resident #1 left the facility with EMS<br><br>A review of a resident transfer form dated 5/20/13 indicated the reason for Resident #1's transfer was rectal bleeding and on heparin therapy three times a day however there were blank sections throughout the form that had not been completed.<br><br>During an interview on 05/30/13 at 1:45 PM Nurse #1 stated he worked the 7:00 AM to 3:00 PM shift and explained he was giving change of shift report on 05/20/12 to the 3:00 PM to 11:00 PM nurse and a nurse aide reported to them Resident #1 had blood in his bowel movement. Nurse #1 stated after he finished report he went with the 3:00 PM to 11:00 PM nurse to Resident #1's room and Resident #1 had a brown and dark red bowel movement. He verified he did not document any nurse's notes regarding the rectal bleeding because he was finished with his shift. | F 514 | 4. The DCS/Nurse Manager will conduct QI monitoring to ensure nursing assessment are completed on residents experiencing a change in condition and/or status post a resident incident, notification of the physician for further orders, timely transfers to a higher level of care as applicable, notification of the RP and documentation of the nursing assessment and chain of events in the resident's medical record. QI monitoring will be conducted 5 times a week for 4 weeks, 3 times a week for 4 weeks, 1 time a week for 4 weeks, and then 1 time monthly for 3 months, using a sample size of 3. DCS/Nurse Manager will report findings of QI monitoring to the QA/PI Committee monthly x 6 months for continued substantial compliance and/or revision. | |

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| F 514 | Continued From page 14<br>During an interview on 05/30/13 at 3:23 PM Nurse #2 explained they were supposed to document pertinent information in a residents medical record and verified she did not fill out all of the sections on the SBAR form and did not date and sign it. She verified there were no vital signs on the form except for an oxygen saturation percentage. She further explained she did not document the detail and time of each time the Nurse Aides reported to her when Resident #1 had rectal bleeding during the 3:00 PM to 11:00 PM shift on 05/20/13.<br><br>During a telephone call on 05/30/13 at 9:07 PM Nurse #3 stated he worked the 11:00 PM to 7:00 AM shift on 05/20/13. He explained he wrote his notes on the progress note sheet on the SBAR form after Resident #1 left for the hospital and wrote a time line in the progress notes to show when EMS was called and when the resident left the facility. He further stated he remembered the residents vital signs were stable but was not sure if they were documented.<br><br>During an interview on 05/31/13 at 12:11 PM the Assistant Director of Clinical Services stated the SBAR form should be completed when a resident had a change of condition and it should be filled out and there should be documentation in the nurse's notes. She further stated it was expected that the SBAR form should be completed in its entirety and the progress note sheet should be filled out completely. She verified the transfer form for Resident #1 was incomplete and should be completely filled out.<br><br>During an interview on 05/31/13 at 1:16 PM the Director of Nursing (DON) stated she expected | F 514 | | |

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| F 514 | Continued From page 15<br>for the SBAR forms to be completed, signed and dated. She further stated Resident #1 should have had vital signs documented and documentation of bleeding in the nurse's notes. | F 514 | | |