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
	345083	A. BUILDING ______ B. WING ______	06/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - RUTHERFORDTO	188 OSCAR JUSTICE RD RUTHERFORDTON, NC 28139

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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 medical record review, review of the dialysis center contract, and interviews with facility staff and dialysis center staff the facility failed to implement orders from the dialysis center for 1 of 1 sampled resident receiving dialysis to meet their highest nutritional needs (Resident #85). The findings included: Resident #85 was admitted to the facility 01/25/13 with diagnoses which included chest pain, chronic kidney disease, diabetes, muscle weakness, hypertension, anemia, and nephrotic syndrome. Review of hospital records prior to admission to the facility noted Resident #85 was started on dialysis during the admission to the hospital. The care plans for Resident #85 included the following: 1. 02/14/13 (Resident's name) has chronic renal insufficiency and requires dialysis three days per week 2. 03/28/13 Potential for weight fluctuations	F 309	**White Oak of Rutherfordton does ensure that each resident receives the care and services to attain and maintain the highest practicable physical, mental and psychosocial wellbeing in accordance with the comprehensive assessment and plan of care.** **Resident #85's dietary supplement recommendations were clarified with the dialysis Registered Dietitian (RD), then reviewed and approved by the attending physician on 06/20/13.** **Resident #85 is receiving the dietary supplements per physician orders.** **Any recommendations including dietary supplements by the Dialysis Clinic for Resident #85, and any other residents receiving dialysis will be communicated to the facility's DON/ADON via fax at 828-286-9070, and the recommendations will be forwarded to the physician and the Dietary Manager. The recommended orders will be processed as approved by the physician.**	7/19/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wanda J. Stone, RN DON
TITLE: Acting Administrator
(X6) DATE: 7/15/13

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 7/9/13 mh

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F 309	Continued From page 1 related to medications, medical conditions, high weight status and history of edema. The approaches to this problem area included, "Liaison with dialysis clinic as needed." Review of the undated dialysis center contract noted the following in the contractual agreement between the facility and the dialysis center: Under (dialysis) Center Obligations, "Without limiting the foregoing, Center shall provide to Facility information on aspects of the management of a Designated Resident's care related to the provision of dialysis services". Review of physician orders in the medical record of Resident #85 included the following orders: -05/20/13- Nepro (a caloric/protein supplement formulated for residents with renal disease) 8 ounce can with meals twice daily due to dialysis/weight loss/low albumin -05/22/13- Beneprotein (a powdered protein supplement) one scoop, twice daily due to low albumin (a lab test which reflects protein status). Review of the medical record of Resident #85 noted a copy of the Diet/Supplement/Tube Feeding Communication Forms in the medical record with the following diet order changes since admission to the facility: -01/25/13- Regular diet with no concentrated sweets (LCS) -05/20/13- Nepro 8 ounce can twice a day with meals -06/10/13- No milk, cheese or dried beans The tray card for all three meals for Resident #85 was reviewed and included Nepro at breakfast and supper; dislikes of oatmeal, milk, cheese and	F 309	**The facility's Registered Dietitian or designee will review weekly the Dialysis Center's dietary recommendations via the progress notes, care plans, physicians orders and Medication Administration Records for the duration of the dialysis treatments.** **Quality Assurance of the dialysis residents' supplement and other approved physician orders will be reviewed Monday – Friday during morning report meeting for 8 weeks and monthly thereafter.** **The Dietary Manager, Director of Nursing and the Registered Dietitian are responsible for the ongoing compliance of tag F309.**	

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F 309	Continued From page 2 dried beans and to include 2 packs of Beneprotein in food with each meal Review of labs in the medical record of Resident #85 noted the following albumin levels with 3.5-4.8 being the normal parameters. 01/22/13 1.8 01/25/13 2.2 01/28/13 2.4 02/08/13 2.8 03/04/13 3.0 04/01/13 3.2 On 06/19/13 at 11:30 AM the Food Service Director (FSD) stated the facility policy was to not write physician orders for nutritional supplements. The FSD explained most nutritional supplements are provided to residents directly on their meal tray and the need for supplementation would be communicated via the Diet/Supplement/Tube Feeding Communication Form. The FSD stated the Diet/Supplement/Tube Feeding Communication Forms were kept in each individual residents medical record and could be referenced to know any changes to a residents nutritional regimen. The FSD stated the dialysis center communicated any needs through phone calls or dialysis center physician orders. The FSD stated physician orders for nutritional supplements would be written on the Diet/Supplement/Tube Feeding Communication Form. On 06/19/13 at 11:45 AM in a telephone interview the facility consultant dietitian (RD) stated she was present at the facility once a week to assist with nutritional consulting needs. The RD stated it was a facility policy to not write orders for	F 309		

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F 309	Continued From page 3 nutritional supplements and nutritional supplemental needs were based on her individual judgement. The RD stated the dialysis center typically sent any recommendations or orders either by fax or a phone call. Specific to Resident #85, the RD stated she didn't think Resident #85 cared for the Nepro. The RD stated because she didn't think Resident #85 was drinking the Nepro she increased the amount of Beneprotein sent with each meal tray. The RD stated this was why he was sent two packs of Beneprotein per tray. Review of the entire electronic medical record of Resident #85 noted the following entries by the consultant RD: -02/08/13- New admission and recently started on maintenance hemodialysis. He has multiple medical issues, some of which may influence his weight status. Height: 71" Weight: 245. Resident has lost 35.8 in one week. Will continue weekly weights to establish dry weight. He has been a resident at this facility in the past. His weight at that time was around 300 and weight record shows wide variances in his weight trends. He receives and tolerates a regular LCS diet without noted difficulty. He consumes greater than 75% at meals per charting. Some skin impairment noted-see wound notes. Resident has full upper dentures and a few natural lower teeth. He is alert and verbal and able to feed himself. Available lab work can be located in medical chart. No dietary changes at this time. Will monitor weight and intervene as appropriate -03/01/13- Resident has gained 8% in 30 days. This is following a drastic loss. His weight has been stable with some fluctuation for 2 weeks. Resident has medical conditions and medications that are likely causing the weight fluctuations.	F 309		

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High weight status noted. Resident receives a regular LCS diet and consumes greater than 75% at meals per charting. No dietary changes are needed at this time. Will be of assistance as needed. Expect weight to stabilize within 265-275 range.
-03/22/13- Received order recommendation from dialysis clinic for Nepro 4 oz twice daily. Will add Nepro 8 oz to one meal daily to equal the same amount.
-06/18/13- Resident was tried on Nepro due dialysis/weight loss/low albumin per dialysis clinic recommendation. He continually refused this supplement and it has been discontinued per his request.

On 06/20/13 at 10:18 AM in a telephone interview with staff at the dialysis center they stated their practice was to make a copy of any dialysis physician orders and attach them to the Inter-facility Transfer Patient Report (a report generated by the facility every time a resident leaves for dialysis to record "Facility Report to Dialysis Center" and "Dialysis Center Report to White Oak"). Dialysis staff stated as time allowed they would attach the copy of orders but, at a minimum, they always faxed a copy of physician orders to the facility with expectation the orders were followed. This staff member stated that, as time allowed, nursing staff would retrieve the confirmation to the fax to verify the order was sent. This staff member stated they would provide a copy of all orders that had been sent for Resident #85 and fax verification.

On 6/20/13 at 10:45 AM a copy of physician orders from dialysis were sent to the facility for review. These orders included the following:

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F 309	Continued From page 5 -02/22/13- A physician's order for 1) High protein diet (double portions of meat and eggs) with no added salt on trays and 2) Dialyvite or renal vitamin equivalent: one orally every day (on dialysis days give after dialysis and 3) Beneprotein 1 scoop, twice a day. -03/18/13- A physician's order to 1) Continue Beneprotein, 1 scoop twice a day and 2) Nepro, 4 ounces twice a day -05/08/13- A physician's order to give double portions of meat and eggs with meals On 06/20/13 at 10:45 AM dialysis staff reported fax confirmation was found for the orders 02/22/13 and 03/18/13 (which noted a packet of information had been sent to the facility which included these orders). Dialysis staff stated although fax confirmation could not be found for the 05/08/13 order, written on the 05/08/13 order was "sent to nursing home" by the staff member that took the order. The dialysis staff reported the specific fax number these orders had been sent to at the facility. On 06/20/13 at 11:36 AM the Administrator stated the facility had three fax machines; one at each of the two nurses stations and one located in the front office. The Administrator stated the fax number dialysis reported sending orders to was located at the front office. The Administrator stated multiple staff processed any paperwork that came from the front office fax machine and there wasn't a definite place the physician orders might have been placed. The Administrator stated staff might have put the dialysis physician orders in the mail box of the Food Service Director, the resident's physician, the Director of Nursing, the consultant dietitian or the box for the	F 309		

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F 309	Continued From page 6 nurses station. The Administrator stated she could not explain what might have happened to the faxed orders for Resident #85 that had been sent from the dialysis center. At the time of the interview the Administrator asked the nurse that typically worked with Resident #85 on first shift and this nurse reported she did not recall seeing any fax physician orders related to Resident #85. This nurse did state that Resident #85 typically returned from dialysis after she left (on second shift) and suggested second shift nursing staff might have information about the orders. On 06/20/13 at 10:55 AM in a telephone interview the Physician of Resident #85 stated he expected to see any orders sent from the nephrologist at the dialysis center so he would be aware of any orders and could, in turn, write a facility order. The Physician stated he was not aware the facility was not obtaining physician orders for nutritional supplements. On 06/20/13 at 11:48 AM the FSD stated the only fax information she had been given from the dialysis center specific to Resident #85 was a form to include specific low phosphorous foods to his diet. The FSD stated this was what led to the 06/10/13 Diet/Supplement/Tube Feeding/Communication Form with instructions for "no milk, cheese, dried beans". The FSD stated she was not aware of the 02/22/13 orders for high protein diet (double portions of meat and eggs) with no added salt on trays, Dialyvite or renal vitamin equivalent, Beneprotein: 1 scoop twice a day; the 03/18/13 order to continue Beneprotein, 1 scoop twice a day or the 05/08/13 order to give double portion of meat and eggs with meals.	F 309		

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On 06/20/13 at 9:45 AM the facility consultant RD stated she had time to review the electronic record of Resident #85 and understood the concerns regarding communication of nutritional supplementation. The consultant RD stated she was not aware of the dialysis physician orders dated 02/22/13, 03/18/13 and 05/08/13 for Beneprotein, double portions of meat and eggs, no added salt diet, Dialyvite or renal vitamin which was why they were not included with the diet regimen of Resident #85. The RD stated the renal vitamin would not be provided by the dietary department and would have required a physician's order. The RD verified Resident #85 did not have orders for a renal vitamin. The RD stated the facility had not started ordering and using Beneprotein until recently so it would not have been available at the time it was first ordered on 02/22/13. The RD stated she realized there was a communication breakdown between dialysis and the facility. The RD stated she expected any physician orders from dialysis that related to nutrition needs of resident to be put in her mail box so they could be addressed. The RD stated she didn't know what might have happened to the orders that had been sent to the facility from dialysis specific to Resident #85.

On 06/20/13 at 3:00 PM the nurse that routinely works with Resident #85 on second shift stated she is usually present when Resident #85 returns from dialysis. This nurse stated Resident #85 typically comes back with the Inter-Facility Transfer Patient Report form. The nurse stated she did not recall ever seeing any orders attached to this form or any faxed orders from dialysis specific to Resident #85.

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F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews the facility failed to notify the provider pharmacy the readmission medication changes (Lovenox Injectable and Cardizem dose) for timely dispensing of the required stock of prescribed medications for 1 of 1 readmitted resident observed for medication administration (Resident #74). The findings included: A review of the facility pharmacy policy and	F 425	**White Oak of Rutherfordton provides routine and emergency drugs to meet the needs of the residents.** **Resident #74 received medication as ordered including the Lovenox and Cardizem, and readmission orders were re-faxed to the Pharmacy on 06/19/13.** **The licensed nursing staff were re-educated by the Staff Development Coordinator (SDC) on processing physician orders to facility's Pharmacy. Re-education completed on 07/15/13.** **The process of the re-education includes the following: Upon residents' readmission, physician orders are faxed to the facility's Pharmacy within 4 hours of the readmission. The faxed physician orders are marked with a fax stamp and dated on the day the physician orders were faxed. The nursing staff will obtain a copy of the transmit confirmation record to ensure that the fax was transmitted. The confirmed transmit confirmation record will be placed in the ring binder with a copy of the physician orders.**	7/19/13

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F 425	Continued From page 9 procedures dated February 7, 2013 under 'Ordering and receiving medications from pharmacy' included: that all new admission physician orders and telephone orders are to be transmitted electronically to the pharmacy for appropriate changes in patient profile for accurate dispensing. Resident #74 was readmitted on 06/11/13 after a hospital admission on 06/07/13. Resident #74's diagnoses included aftercare hip fracture, atrial fibrillation, difficulty in walking and acute delirium. A review of the physician orders dated 06/11/13 included an order to continue Lovenox 40 mg (milligrams) injection every day until June 29, 2013 and the oral medications included Cardizem 60 mg every 6 hours (changed from 45 mg every 6 hours). A review of Resident #74's June 2013 electronic Medication Administration Record (eMAR) revealed the Lovenox injection and Cardizem were scheduled to be administered at 8:00 AM daily. Resident #74 was observed for medication pass on 6/19/13 at 8:02 AM. Nurse #1 was observed administering medications to Resident #74. Nurse #1 pulled all the oral medications from the medication cart including Cardizem 30mg two tablets. The pharmacy label instructions on Cardizem were to administer one and a half tablets (45 mg) and Nurse #1 stated that the dose had been changed during the readmission on 6/11/13 and the current eMAR reflected Cardizem 60 mg. Further observation revealed an active order of Lovenox 40 mg injection, but Lovenox injection was not available on the cart. Nurse #1 stated that she would obtain the injection from the	F 425	**The newly hired licensed nursing staff will receive this training during orientation.** **The Registered Nurse Supervisor, SDC, DON or ADON will conduct daily audits of the transmit confirmation record within 24 hours of readmissions to confirm the fax was transmitted and received to the facility's Pharmacy.** **The daily audits of readmitted residents' medication orders will be conducted for 4 weeks, then monthly for 2 months, then further audits conducted as recommended by the Quality Assurance meetings.** **The Pharmacist will continue to review the Medication Administration Records monthly to assure ongoing compliance of F425.** **The Quality Committee, will review any issues and trends from the audits and Pharmacist Reports weekly for 4 weeks, then monthly for 2 months, and then as indicated.** **The Administrator and DON are responsible for the ongoing compliance of F425.**	7/19/13

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backup pharmacy and then request a refill from the provider pharmacy as it had to be continued until 06/29/13.

An interview with the Assistant Director of Nursing (ADON) on 06/19/13 at 8:30 AM revealed no evidence was available for having reordered Lovenox injection from the pharmacy prior to 06/19/13. The ADON stated that all physician orders and admission/readmission orders were verified by the admitting nurse, confirmed by the physician and double-checked by a second nurse who transcribed the orders to the eMAR. The medication orders were then faxed to the pharmacy for their documentation and updating. The ADON was unable to provide any documented evidence that the readmission orders for Resident #74 had been successfully faxed to the pharmacy.

A continued interview with the ADON and the Director of Nursing (DON) on 06/19/13 at 8:50 AM confirmed that it was the facility's policy all admission/readmission orders be faxed to the pharmacy upon verification for completing the documentation, but for Resident #74 the readmission orders dated 06/11/13 were not faxed as there were no change in medications.

A telephone interview with the pharmacist at the provider pharmacy on 06/20/13 at 8:45 AM, confirmed the readmission medication orders of 06/11/13 for Resident #74 were not faxed to the pharmacy prior to 06/19/13 and hence the Lovenox 40 mg injection order was not refilled.

An interview with Nurse #2 on 6/20/2013 at 3:02 PM revealed she was one of the nurses involved

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F 425	Continued From page 11 in the admission transcription process for Resident #74 on 06/11/13 and stated the readmission orders were not faxed to the pharmacy as there were no medication changes.	F 425		