

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

DEC 30 2013

PRINTED: 12/13/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345365	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2013
NAME OF PROVIDER OR SUPPLIER KINSTON HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM RD KINSTON, NC 28501	
(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
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to remove sutures as ordered for 1 of 1 sampled residents (Resident #2). Findings included:</p> <p>Resident #2 was admitted to the facility on 5/21/13 with cumulative diagnoses of chronic pain and memory loss.</p> <p>Resident #2's Quarterly Minimum Data Set (MDS) dated 8/15/13 showed that Resident #2 was moderately cognitively aware and had had three falls since the prior assessment period.</p> <p>Review of the Physician's Telephone Orders dated 7/28/13 showed an order to send Resident #2 to the Emergency Room for evaluation and treatment.</p> <p>Review of the Emergency Physician Record dated 7/28/13 showed Resident #2 had received a 0.5 centimeter L shaped laceration to the forehead. The laceration was closed with six sutures.</p> <p>Review of the hospital Patient Visit Information</p>	F 309	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>The sutures for resident #2 were removed on 9/7/2013 by ER physician.</p> <p>The Physician Orders and Medication Administration record was reviewed by DNS and designee's to identify resident's that may have been affected with no other variances being found. Review completed 12/16/2013.</p> <p>The Staff Development Coordinator and/or designee will provide education on the process of Physician Order to Medication Administration Record monthly reconciliation with Licensed Nurses. Completion date 12/22/2013.</p>	12/22/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

K. Speller Administrator 12/29/13

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.

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F 309	<p>Continued From page 1 dated 7/28/13 showed that the sutures were to be removed in 7-10 days.</p> <p>Review of the July 2013 Medication Administration Record (MAR) showed a hand written order "FYI (for your information) remove stitches to forehead in 7-10 days" was added on 7/28/13.</p> <p>Review of the Resident Progress notes for 7/29/13 and 7/30/13 showed the forehead laceration with sutures was being assessed. The notes were reviewed from 7/30/13-9/8/13 and there were no further notes regarding Resident #2's forehead wound after 7/30/13 at 3:00 PM.</p> <p>Review of the 7/30/13 weekly Skin Assessment showed no initials or assessment.</p> <p>Review of Resident #2's 8/1/13-9/3/13 weekly Skin Assessments showed no skin issues.</p> <p>Review of the August 2013 MAR did not show the order for suture removal.</p> <p>Review of the Resident Progress notes dated 9/7/13 showed Resident #2 was sent to the Emergency Room due to a complaint of severe pain to the back of the head.</p> <p>Review of the Emergency Physician Record dated 9/7/13 showed Resident #2 was seen for a lump to the back of the head. Resident #2's physical exam showed one healed laceration with sutures in place. The Emergency Room course included suture removal for sutures placed 7/28/13 that were to have been removed in 7-10 days.</p>	F 309	<p>The DNS and/or designee will perform random audits on each unit of the Medication Administration Record against the physician telephone orders and the Order Listing Summary to ensure accuracy and to validate that orders are transcribed to the Medication Administration Record. The Director of Nursing will report to Quality Assurance identified trends or patterns. Auditing will be done weekly for 4 weeks then monthly for 3 months. Any negative findings will be corrected at the time of discovery in accordance to the Standard; findings of the audits will be submitted to the Quality Assurance and Performance Improvement Committee.</p> <p>Completion date 12/22/2013</p>		

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F 309	<p>Continued From page 2</p> <p>In an interview on 11/26/13 at 11:10 AM Nurse #1 stated she remembered she had asked Resident #2 if she could remove the sutures. She indicated she had documented that her request had been refused. Nurse #1 looked through Resident #2's Progress Notes from 7/31/13-9/8/13 and stated she could find no documentation regarding Resident #2's forehead laceration. Nurse #1 stated she had been the nurse who had done the first check to compare the July MAR to the August MAR to make sure all the orders had been carried over to the new month (August). She stated the line for the second check did not have a signature and she did not know who should have done the second check. She indicated the order had been left off the August MAR.</p> <p>In an interview on 11/26/13 at 12:00 PM the Director of Nursing (DON) stated the purpose of a first and second check for new MAR's was to make sure no orders were missed. She indicated she did not know who was supposed to do the second check or why it was not done. She stated it was her expectation that the staff nurses would have done a first and second check on Resident #2's August MAR. The DON stated the suture removal order was just overlooked. When asked if Resident #2's sutures had been removed she stated she was unable to locate any documentation that Resident #2's sutures had been removed or to locate a nurse who would say they had removed the sutures.</p>	F 309			