

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

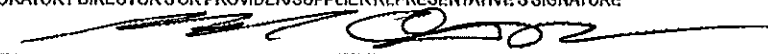
PRINTED: 02/03/2014
 FORM APPROVED
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/17/2014
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(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 157 SS=G	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, physician, and staff interviews, the facility failed to immediately notify the physician when 1 of 1 sampled residents</p>	F 157	<p>This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law</p> <p>F157</p> <ol style="list-style-type: none"> Corrective action will be accomplished for the resident found to have been affected by the deficient practice; <ul style="list-style-type: none"> Resident no longer resides in the facility Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice; <ul style="list-style-type: none"> On January 17, 2014 the Director of Health Services, Unit Managers, Unit Coordinator and Nursing Supervisors have reviewed all Medication Administration records with physicians notification regarding residents who have refused two consecutive doses of vital medications per facility policy. Measures put into place or systemic changes made to ensure that the deficient practice will not occur; <ul style="list-style-type: none"> On January 17th, 2014 Clinical Competency Coordinator and/or Nursing Managers have educated Licenses Nurses on Physician Notification related to the Medication Administration Protocol that states the Physician would be notified after two consecutive doses of a vital medication has been missed. 	2/20/14

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

TITLE

(X6) DATE



ADMINISTRATOR

3/12/14

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 157	<p>Continued From page 1 (Resident # 3) was found arousable only to sternal rub. Findings included.</p> <p>Resident # 3 was admitted to the facility on 12/23/2013 with re-admissions on 1/2/2014, 1/6/2014, and 1/10/2014. Diagnoses included decompensated liver cirrhosis secondary to Hepatitis C complicated by portal hypertension, anemia, diabetes mellitus type 2 on insulin, and stage III chronic kidney disease.</p> <p>Hospital records reviewed documented that in November 2013 Resident # 3 had a Transjugular Intrahepatic portosystemic shunt (TIPS) which was a procedure to create new connections between two blood vessels in the liver due to severe liver problems.</p> <p>The Nurses' notes for 1/6/2014 documented that Resident #3 arrived at the facility around 6 pm, was alert and responsive with no complaints of pain or discomfort.</p> <p>On the Admission Physician's Order Sheet dated Jan. 6, 2014 Lactulose 30 ml po q 6 hrs at 6 am, 12 noon, 6 pm, and 12 midnight and Rifaximin 550 mg po bid at 9am and 5 pm were noted. Also noted was Lactulose [20 gm/30 ml] po q 4 hrs as needed (titrate to 3-4 bowel movements) per day</p> <p>The Medication Administration Record (MAR) for January 6-31, 2014 in review revealed that on 1/6/2014 Lactulose 30 ml po was initialed given at 6 pm, had no initials for 12 midnight or 6 am and had circled initials for 12 noon. The Rifaximin 550 mg po bid had no initial for 5 pm on 1/6/2014 and a circled initial for 9am on 1/7/2014. The back of the MAR documented that at 9 am and 12 noon</p>	F 157	<ul style="list-style-type: none"> The corporate policy committee has reviewed the Change of Condition Care Guard Program, Physician notification "states the Physician would be notified after two consecutive doses of a vital medication has been missed. Education began on 1/17/14 through 1/26/14 for Licensed Nurses related to the protocol, Licensed Nurses not in attendance will be educated prior to their next scheduled shift . Physician notification of after two consecutive doses of a vital medication has been missed has been added to the general orientation of Licensed Nurses upon hire. The Licensed Nurses complete a Medication Administration Record review daily to identify medications that have not been administered to the residents and to validate that the Physician has been notified. The Licensed Nurses document the results of the review on a "Medication shift to shift review" form. The Director of Health Services The Director of Health Services and/or Nurse Managers review the Licensed Nurse "Medication shift to shift review form" weekly to validate the completion audit as well as the verification that the notification to the physician has been completed. This review will be completed weekly for four weeks, then monthly for 3 months then as directed by the Quality Assurance Committee. 		

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F 157	<p>Continued From page 2</p> <p>all meds were held due to resident very drowsy at 9am and unable to rouse at noon. The MAR had not documented any PRN (as needed) doses of Lactulose given.</p> <p>On 1/17/14 at 2 am the Nurses' notes indicated no distress was observed for Resident #3. At 8 am Resident #3 was assessed by the nurse manager and aroused enough to open eyes with sternal rub being done and moaned a little. Will continue to monitor and have MD (physician) to see patient today.</p> <p>The 12pm note indicated the nurse manager assessed Resident #3 and found no changes.</p> <p>A review of the Physician's 1/7/2014 Transition into care note revealed the following. After hospitalization the Lactulose was titrated up to q 6 hrs. He was transferred back to the facility on 1/6/2014 and it is not clear whether he tolerated his oral medications. Today on my exam he was not responding to stimulation, painful stimulation, or sternal rub. Staff stated resident not able to take medications due to somnolence, decreased level of consciousness. Patient will be transferred to the hospital via EMS (emergency medical services).</p> <p>The Nurses' note for 2:30 pm documented the MD was with the patient and orders given to send the resident to the hospital. At 3:50 pm 911 was called and at 4:15 pm Resident #3 was transported to the hospital</p> <p>On 1/17/2014 at 8:45 am Nurse #5 stated that on 1/7/2014 when she went to give Resident #3 his morning medications he was so lethargic that he could not take his medications. His medications</p>	F 157	<ul style="list-style-type: none"> The policy has been reviewed by the corporate policy committee "Change of Condition Care Guard Program: states " acute change of condition is a sudden, clinically important deviation from a patients/residents baseline in physical, cognitive, behavioral or functional domain. Communication and in depth discussion of an acute change of condition must occur with the physician and facility management in a timely manner when findings are observed Education began on 1/17/14 through 1/26/14 for Licensed Nurses related to the protocol, Licensed Nurses not in attendance will be educated prior to their next scheduled shift . Licensed staff will receive education Monthly with follow up testing related to describing a resident's symptoms and/or condition by the Clinical Competency Coordinator, Director of Nursing and/or Nurse Managers. This training and testing shall include review of specific examples of changes in condition (utilizing the interact II and Care to Learn web based education,) that should be reported to the physician. The Director of Nursing reviews the daily nursing report sheet and compares the documentation to validate the physician has been notified of any acute change of condition and documents on the " Notification Review Form". This review is completed daily for one week, weekly for four weeks then monthly for 4 months. 		

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F 157	<p>Continued From page 3</p> <p>at 1pm on 1/7/2014 were also held due to the lethargy and then he was sent to the hospital. Nurse #5 said the MD or NP was there on the morning of 1/7/2013 and assessed Resident #3 and said if he wasn't more alert by afternoon to send him to the hospital.</p> <p>During an interview on 1/17/2014 at 10:10 am the physician (also the Medical Director for the facility) who sent Resident #3 to the hospital on 1/7/2014 stated that she saw him on 1/7/13 for a re-admission note. She was not sure what time she saw Resident #3, but thought it was around noon and the nurse reported that he had not taken his scheduled Lactulose for her due to his lethargy. The physician said when she examined Resident #3, he was limp and very lethargic. She indicated he did not respond at all for her sternal rub. She added that with his advanced liver disease missing 1 or 2 doses of Lactulose would lead to the same effect. Asked when he missed his doses what were her expectations of the nurse, she responded that she expected the nurse to call right away. When Resident #3 was arousable only to sternal rub, she would have expected someone to call the physician service or the physician herself. If she had known he had missed his medications and had lethargy, she would have sent him to the hospital right away.</p> <p>During an interview on 1/17/2014 at 2:33 pm, the nurse manager stated that if she knew the physician was coming to the facility that day, she waited for the physician to come to the floor to see the patient to inform them about changes. She added that when the nurse told her Resident #3 was lethargic on 1/7/2014 and she assessed the resident she was not aware that he had missed any doses of his Lactulose. The nurse</p>	F 157	<ul style="list-style-type: none"> The root cause analysis was completed by Dr. Jackson on February 27, 2014 thru March 1, 2014. Existing policy and procedures for when to notify a physician and facility management, including staff responsibility on a significant change in condition (Uni-Guard) in order to strengthen this program we retrained licensed and non-licensed by March 10, 2014. In order to strength the ongoing education of licensed personnel, additional training and follow up testing to licensed staff was provided to include bowel sounds, heart sounds, fluid volume and cardiac assessment was completed as of March 10, 2014. <p>4. Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained.</p> <ul style="list-style-type: none"> The Director of Health Services will present the findings of the Medication Administration Review with physician notification to the Quality Assurance and Performance Improvement Committee monthly for review and recommendation for revisions. The Clinical Competency coordinator will present the results of the educated related to training and follow up testing to the Quality Assurance / Performance Improvement committee for review, recommendations and revision 		

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F 157	Continued From page 4 manager further stated that she didn't check the MAR as she expected her nurses to let her know of missed medications. She added that none of the nurses told her Resident #3 had missed any medications. On 1/17/2014 at 4:49 pm the Director of Nurses (DON) was asked what her expectations were of her nurses if a resident had altered mental status such as arousing only to sternal rub. The DON said she expected the nurse to notify the physician.	F 157	<ul style="list-style-type: none"> The Director of Health Services will present the findings of the "Notification Review" of physician notification to the Quality Assurance and Performance Improvement Committee monthly for review and recommendation for revisions. 		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit;	F 272	<p>F272</p> <p>1. Corrective action will be accomplished for the resident found to have been affected by the deficient practice;</p> <ul style="list-style-type: none"> A significant correction was completed for resident # 5. Resident #9 diagnosis was dry skin which is not able to be coded on the MDS. <p>2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice;</p> <ul style="list-style-type: none"> The Director of Health Care Service, Unit Managers and Nurse Management conducted functional limitation test on all resident on 2/14/14 and correlated with the last MDS to validate correct coding of the MDS. Case Mix Director was educated by the Clinical Reimbursement Consultant on 1/16/14 with return demonstration (to the Senior Nurse Consultant) on 1/17/14 for the correct way to perform the functional limitation assessment. The facility reviewed the residents weekly skin observations to validate the accuracy of MDS coding on 1/28/14 for skin integrity conditions.. 	2/20/14	

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F 272	<p>Continued From page 5</p> <p>Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews, resident and staff interviews, the facility failed to accurately code the MDS (Minimum Data Set) for 2 of 11 sampled residents. (Residents #9 and #5).</p> <p>Findings included:</p> <p>1. Resident #9 was admitted to the facility on 6/18/12 with diagnoses which included: bipolar disorder, psychotic disorder, diabetes mellitus, diabetic neuropathy, left sided paresis, morbid obesity, muscle weakness, and late effect cerebrovascular accident.</p> <p>Review of the Dermatology Consult dated 11/5/13 revealed Resident #9 had atrophy of both forearms with xerosis (dry skin). The Dermatologist concluded the resident's skin may have been photo exacerbated given the presence on the dorsal arms, only. Also, the resident's scalp was scaling with a few erosions. The</p>	F 272	<p>3. Measures put into place or systemic changes made to ensure that the deficient practice will not occur</p> <ul style="list-style-type: none"> The Case Mix Director was educated by the Clinical Reimbursement Consultant on 1/16/14 with return demonstration (to the Senior Nurse Consultant) on 1/17/14 on completing the functional limitation assessment. The functional limitation test will be added to the new orientation for Case Mix Directors. The Clinical Reimbursement Consultant (CRC) and/or Senior Nurse Consultant (SNC) will review 10% of completed MDS's per month for six months, to ensure functional limitation assessment is completed appropriately. The CRC and/or the SNC will conduct the function limitation test on those 10% of the residents, to validate the MDS is accurate. The Director of Health Care Services will trend the CRC and/or SNC audit and present to the Quality Assurance / Performance Improvement Committee Monthly. The Director of Health Care Services will reviews the weekly skin observation completed monthly to validate the MDS coding and skin observations identify skin integrity areas. 	

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F 272	<p>Continued From page 6</p> <p>recommendations were as follows: apply barrier cream on dorsal hands and forearms every morning; apply (anti-itch lotion) at night for burning; and, apply (anti-itch lotion) daily for scaly skin on arms. The recommendation for the resident's Seborrheic dermatitis was to wash the resident's scalp with anti-fungal shampoo three times each week, leave on ten minutes before rinsing.</p> <p>The review of the Physician's Order dated 11/5/13 revealed that Resident #9 was to have (anti-itch lotion) applied daily to the scaly skin on her arms; and, her scalp was to be washed three times each week with (anti-fungal shampoo) which was to be left on for ten minutes before rinsing.</p> <p>Review of the annual MDS (Minimum Data Set) dated 11/7/13 indicated Resident #9 was cognitively intact and had no skin problems.</p> <p>During an interview on 1/17/14 at 11:55 am, the MDS Coordinator indicated Resident #9's skin problems did not trigger on the MDS but should have.</p> <p>2. Resident #5 was admitted to the facility on 6/1/11 with diagnoses which included: brain injury with aggressive behaviors, abnormal posture, neurological neglect syndrome, and flaccid hemiplegia on her non-dominant side.</p> <p>Review of the quarterly MDS dated 11/6/13 indicated Resident #5 had no functional limitation in range of motion of her upper and lower extremities. A review of the Care Plan revealed the resident had the potential for a decline in activities of daily living related to her cognitive</p>	F 272	<p>4. Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained.</p> <ul style="list-style-type: none"> The Director of Health Services will present the trending of the functional limitation assessment completed by the CRC and/or SNC to the Quality Assurance / Performance Improvement Committee for review and revisions as needed. The Director of Nursing Services will present the trending of the skin observation with correlation to the MDS coding to the Quality Assurance and Performance Improvement Committee monthly for review and revision as needed. 		

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F 272	Continued From page 7 Impairment and, her decreased range of motion and tremors. Approaches to this potential decline included the use of a mechanical lift by two staff when transferring the resident. On 1/15/14 at 3:28 pm, two nursing assistants were observed exiting Resident #5's room: one was pushing a mechanical lift and the other was propelling the resident in a highback wheelchair. Both of the resident's feet were elevated and there was a hand splint on her left hand which was resting on a leftsided tray attached to her wheelchair. During an interview on 1/16/14 at 10:27 am, Staff Nurse #3 revealed that Resident #5 required a mechanical lift for transferring due to her inability to ambulate and muscle weakness to the left side of body. During an interview on 1/17/14 at 11:55 am, the MDS Coordinator acknowledged the Range of Motion section of Resident #5's MDS was inaccurately coded.	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280	F280 1. Corrective action will be accomplished for the resident found to have been affected by the deficient practice; • Resident # 9 care plan was updated to include the resident's skin issues. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice; • On 1/28/14 the Director of Health Services, Case Mix Director, and Nurse Managers began correlating resident care plans with weekly body audits to ensure care plans have been updated to include skin concerns.	2/20/14

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F 280	<p>Continued From page 8</p> <p>for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews, resident and staff interviews, the facility failed to update the Care Plan to include the skin problems of 1 of 11 sampled residents. (Resident #9).</p> <p>Findings included:</p> <p>1. Resident #9 was admitted to the facility on 6/18/12 with diagnoses which included: bipolar disorder, psychotic disorder, diabetes mellitus, diabetic neuropathy, left sided paresis, muscle weakness, and late effect cerebrovascular accident.</p> <p>Review of the Dermatology Consult dated 11/5/13 revealed Resident #9 had atrophy of both forearms with xerosis (dry skin). The Dermatologist concluded the resident's skin may have been photo exacerbated given the presence on the dorsal arms, only. Also, the resident's scalp was scaling with a few erosions. The recommendations were as follows: apply zinc oxide barrier cream on dorsal hands and forearms every morning; apply (anti-itch lotion) at night for burning; and, apply (anti-itch lotion) daily</p>	F 280	<p>3. Measures put into place or systemic changes made to ensure that the deficient practice will not occur;</p> <ul style="list-style-type: none"> The Director of Health Services, Case Mix Director and/or Unit Managers will review the daily report sheets for any change in skin integrity and validate the care plan has been updated. This will occur daily for one week, weekly for four weeks and then monthly for four months. The Case Mix Director and/or Director of Health Services will educate the Licensed Nurses on updating care plans for residents with skin issues. Education to be completed by 2/18/14. Education of updating of the care plan has been added to the orientation of Licensed Nurses during general orientation. <p>4. Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained.</p> <ul style="list-style-type: none"> The Director of Health Services / Case Mix Director will present the findings of the Care plan audit to the Quality Assurance / Performance Improvement committee for review and recommendations as needed. 	

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F 280	<p>Continued From page 9</p> <p>for scaly skin on arms. The recommendation for the resident's Seborrheic dermatitis was to wash the resident's scalp with (anti-fungal) shampoo three times each week, leave on ten minutes before rinsing.</p> <p>The review of the Physician's Order dated 11/5/13 revealed that Resident #9 was to have (anti-itch lotion) applied daily to the scaly skin on her arms; and, her scalp was to be washed three times each week with (anti-fungal shampoo) which was to be left on for ten minutes before rinsing.</p> <p>Review of the annual MDS (Minimum Data Set) dated 11/7/13 indicated Resident #9 was cognitively intact and had no skin problems. The facility's updated Care Plan did not include the resident's skin problems.</p> <p>During an observation and interview on 1/15/14 at 2:46 pm, Resident #9 was sitting upright in bed reading. The resident revealed that she preferred and received a bed bath every morning, but was unsure which shift of nursing assistants was responsible for washing her hair twice a week. Resident revealed that she had some sores on her scalp which required a medicated shampoo; therefore, it was important that her hair was washed every few days.</p> <p>During an interview on 1/17/14 at 11:55 am, the MDS Coordinator revealed Resident #9's Care Plan was updated on 11/19/13. She stated that the Care Plan should have been updated to include the resident's dermatitis of her arms and scalp, but was not.</p>	F 280			
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309			

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F 309	<p>Continued From page 10</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 observation, record review, physician, and staff interviews, the facility failed to administer physician ordered medications resulting in two hospitalizations for one of five residents sampled for medication administration (Resident #3). Findings Included:</p> <p>Resident # 3 was admitted to the facility on 12/23/2013 with re-admissions on 1/2/2014, 1/8/2014, and 1/10/2014. Diagnoses included decompensated liver cirrhosis secondary to Hepatitis C complicated by portal hypertension, anemia, diabetes mellitus type 2 on insulin, and stage III chronic kidney disease.</p> <p>Hospital records reviewed documented that in November 2013 Resident # 3 had a Transjugular intrahepatic portosystemic shunt (TIPS) which was a procedure to create new connections between two blood vessels in the liver due to severe liver problems.</p> <p>Record review found no completed Minimum Data Set (MDS). The MDS nurse stated on 1/16/2014 at 10:27 am that Resident # 3 had not been in the facility enough consecutive days to complete the MDS which was in progress.</p>	F 309	<p>F309</p> <ol style="list-style-type: none"> Corrective action will be accomplished for the resident found to have been affected by the deficient practice; <ul style="list-style-type: none"> Resident no longer resides in the facility Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice; <ul style="list-style-type: none"> On January 17, 2014 The Director of Health Services, Unit Managers, Unit Coordinator and Nursing Supervisors has reviewed all Medication Administration records with physicians notification regarding residents who have refused two consecutive doses of vital medications per facility policy. Measures put into place or systemic changes made to ensure that the deficient practice will not occur; <ul style="list-style-type: none"> On January 17, 2014 the Clinical Competency Coordinator and/or Nursing Managers has educated Licenses Nurses on Physician Notification related to the Medication Administration. The policy has been reviewed by the corporate policy committee "Change of Condition Care Guard Program: "protocol that states the Physician would be notified after two consecutive doses of a vital medication has been missed. Education began on 1/17/14 through 1/26/14 for Licensed Nurses related to this protocol. Licensed Nurses not in attendance will be educated prior to their next scheduled shift. 	2/20/14	

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F 309	<p>Continued From page 11</p> <p>The Interim Care Plans for 1/2/2014, 1/6/2014, and 1/10/2014 were reviewed with diabetes, abdominal pain, and skin impairment being addressed.</p> <p>Physician orders reviewed found that on admission 12/23/2013 Resident # 3 was receiving 30 ml (milliliters) (20 g) (grams) of Lactulose and Rifaximin 550 mg (milligrams) bid (two times a day).</p> <p>The Medication Administration Record (MAR) for December 23-27, 2013 documented that Resident #3 received each ordered dose of Lactulose 30 ml po (by mouth) and Rifaximin 500 mg po starting the night of 12/23/2014 and ending with the last dose the morning of 12/27/2014 before going to the hospital.</p> <p>Physician Progress notes for 12/27/2013 were reviewed and documented in part the following: Initially resident was able to sit up in bed and communicate with staff. Today it was reported that he had been presenting with increased lethargy and somnolence since 2 days ago. His ammonia level yesterday was 177 (normal 20-70). On eval very lethargic. Will transfer to the hospital for further management.</p> <p>Review of a hospital Discharge Summary dated 1/2/2014 found that Resident #3 had been admitted on 12/27/2013 with altered mental status secondary to hepatic encephalopathy. Resident #3's ammonia level checked at the facility was 177. The summary noted that the encephalopathy gradually occurred despite receiving the ordered doses of Lactulose 20 gm in 30 ml bid and Rifaximin 550 mg bid. On</p>	F 309	<ul style="list-style-type: none"> Physician notification of after two consecutive doses of a vital medication has been missed has been added to the general orientation of Licensed Nurses upon hire. The Licensed Nurses complete a shift to shift Medication Administration Record review to identify medications that have not been administered to the residents to validate that the Physician has been notified. This review included any omission, or circled medications are to be documented on back of MAR with reason why resident did not receive medication and physician notification. The Director of Health Services and/or Nurse Managers review the Licensed Nurse shift to shift review weekly to validate the completion of the review that includes documentation on back of medication record of reason resident did not receive medication, and that the notification to the physician has been completed. This review will be completed weekly for four weeks, then monthly for 3 months then as directed by the Quality Assurance Committee The facility has reviewed and revised as needed the policy related to significant change in condition and when to notify the physician and facility management. 	

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F 309	<p>Continued From page 12</p> <p>discharge the Lactulose was increased from bid to three times a day (tid) and Resident #3 was counseled on the importance of taking the Lactulose (titrated to 2-3 bowel movements per day. (The liver normally breaks down ammonia, but in liver disease such as cirrhosis the blood may bypass the liver, allowing this poisonous substance to pass to the brain. Here it can impair brain function, causing confusion, drowsiness and finally coma. Per the 2013 Lippincotts Nursing Drug Handbook Lactulose causes the migration of blood ammonia into the colon trapping and expelling it in the feces. Rifaximin is used for reduction of recurrence of hepatic encephalopathy in patients with advanced liver disease.)</p> <p>A review of Nurses' notes found that Resident # 3 arrived at the facility on 1/2/2014 around 5:45 pm, was able to verbalize needs, had no pain or distress. Medications were verified by the nurse practitioner (NP) and faxed to the pharmacy.</p> <p>On the Admission Physician's Order Sheet dated Jan. 2, 2014 Lactulose 30 ml po tid at 9am, 1pm, 5pm and Rifaximin 550 mg po bid at 9am and 5pm were noted.</p> <p>The MAR for 1/2-1/31/2014 was reviewed. For 1/2/2014 the MAR had no initials indicating administration of Lactulose 30 ml po at 5 pm and the initials were circled at 9am and 1pm on 1/3/2014. Rifaximin 550 mg po bid had no initials on 1/2/2014 at 5 pm and the initials were circled for 9am on 1/3/2014. There was no documentation on the back to indicate the reason for missed doses. Circled initials indicated the medication was not given.</p>	F 309	<ul style="list-style-type: none"> The policy has been reviewed by the corporate policy committee "Change of Condition Care Guard Program "states " acute change of condition is a sudden, clinically important deviation from a patients/residents baseline in physical, cognitive, behavioral or functional domain. Communication and in depth discussion with the physician and facility management notification of an acute change of condition must occur in a timely manner when findings are observed. Education began on 1/17/14 through 1/26/14 for Licensed Nurses related to this protocol. Licensed Nurses not in attendance will be educated prior to their next scheduled shift. Licensed staff will receive education Monthly with follow up testing related to describing a resident's symptoms and/or condition by the Clinical Competency Coordinator, Director of Nursing and/or Nurse Managers. This training and testing shall include review of specific examples of changes in condition (utilizing the interact II and Care to Learn web based education,) that should be reported to the physician 		

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F 309	<p>Continued From page 13</p> <p>On 1/3/2014 the notes indicated that at 2 am Resident # 3 was alert and oriented, able to make needs known. At 8 am the nurse manager noted that during rounds Resident #3 was found to be very lethargic and unable to arouse. "Will have Dr. to see this am." At 9 am the note indicated the physician was there to see the patient and new orders were written. At 2 pm the note indicated there was an order to send Resident #3 to the hospital and at 3 pm 911 was there to transport.</p> <p>A physician order dated 1/3/2014 11:30 am was Send pt back to hospital if not more awake this pm.</p> <p>Physician's Progress Note of 1/3/2014 Transition into care was reviewed for the following information. Lactulose was increased to tid ...On eval today pt (patient) was resting in bed, asleep, difficult to arouse, unable to keep eyes open or answer simple questions. According to daytime nurse, he had been like this all morning today and was not able to eat lunch due to AMS (altered mental status). Nighttime nurse reported he was awake and alert "Since he failed to wake up and become more interactive as was his baseline and requested blood work won't be available today, will transfer back to the hospital."</p> <p>A review of the hospital Discharge Summary dated 1/6/2014 noted that Resident # 3 was admitted to the hospital on 1/3/2014 with hepatic encephalopathy with altered mental status and somnolence. His ammonia level on admission was 181. The summary indicated that it was thought the cause was possibly due to missed doses of Lactulose. After being given Lactulose in the hospital by a nasal gastric (ng) tube over 12 hours, Resident # 3 was back to his baseline. On</p>	F 309	<ul style="list-style-type: none"> The root cause analysis was completed by Dr. Jackson on February 27, 2014 thru March 1, 2014. Existing policy and procedures for when to notify a physician and facility management, including staff responsibility on a significant change in condition (Uni-Guard) in order to strengthen this program we retrained licensed and non-licensed by March 10, 2014. In order to strength the ongoing education of licensed personnel, additional training and follow up testing to licensed staff was provided to include bowel sounds, heart sounds, fluid volume and cardiac assessment was completed as of March 10, 2014. <p>4. Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained.</p> <ul style="list-style-type: none"> The Director of Health Services will present the findings of the Medication Administration Review with physician notification to the Quality Assurance and Performance Improvement Committee monthly for review and recommendation for revisions. The Clinical Competency coordinator will present the results of the educated related to training and follow up testing to the Quality Assurance / Performance Improvement committee for review, recommendations and revision. 	

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F 309	<p>Continued From page 14</p> <p>discharge the Lactulose was being given by mouth and was to be given q (every) 6 hours. The patient was instructed to continue his scheduled Lactulose as prescribed to avoid altered mental status again. Instructions noted the Lactulose was to be given for a goal of 3-4 bowel movements a day. If the scheduled dose was not sufficient to achieve 3-4 bowel movements a day extra doses could be given q 4 hours.</p> <p>The Nurses' notes for 1/6/2014 documented that Resident #3 arrived at the facility around 6 pm, was alert and responsive with no complaints of pain or discomfort.</p> <p>On the Admission Physician's Order Sheet dated Jan. 6, 2014 Lactulose 30 ml po q 6 hrs at 6 am, 12 noon, 6 pm, and 12 midnight and Rifaximin 550 mg po bid at 9am and 5 pm were noted. Also noted was Lactulose [20 gm/30 ml] po q 4 hrs as needed titrate to 3-4 bowel movements per day</p> <p>The MAR for January 6-31, 2014 in review revealed that on 1/6/2014 Lactulose 30 ml po was initiated given at 6 pm, had no initials for 12 midnight or 6 am and had circled initials for 12 noon. The Rifaximin 550 mg po bid had no initial for 5 pm on 1/6/2014 and a circled initial for 9am on 1/7/2014. The back of the MAR documented that at 9 am and 12 noon all meds were held due to resident very drowsy at 9am and unable to rouse at noon. The MAR had not documented any PRN (as needed) doses of Lactulose given.</p> <p>On 1/7/14 at 2 am the notes indicated no distress was observed for Resident #3. At 8 am Resident #3 was assessed by the nurse manager and aroused enough to open eyes with sternal rub</p>	F 309			

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F 309	<p>Continued From page 15</p> <p>being done and moaned a little. Will continue to monitor and have MD (physician) to see patient today.</p> <p>The 12pm note indicated the nurse manager assessed Resident #3 and found no changes.</p> <p>A review of the Physician's 1/7/2014 Transition into care note revealed the following. After hospitalization the Lactulose was titrated up to q 6 hrs. He was transferred back to the facility on 1/6/2014 and it is not clear whether he tolerated his oral medications. Today on my exam he was not responding to stimulation, painful stimulation, or sternal rub. Staff stated resident not able to take medications due to somnolence, decreased level of consciousness. Patient will be transferred to the hospital via EMS (emergency medical services).</p> <p>The Nurses' note for 2:30 pm documented the MD was with the patient and orders given to send the resident to the hospital. At 3:50 pm 911 was called and at 4:15 pm Resident #3 was transported to the hospital</p> <p>The hospital Discharge Summary dated 1/10/2014 for an admission on 1/7/2014 was reviewed. The Summary indicated that Resident # 3 was again admitted for portosystemic encephalopathy. His ammonia level was 163. Search for the cause of the recurrent hepatic encephalopathy "revealed medication noncompliance by the facility." The Summary added that the physician spoke with the 7 am to 3 pm nurse and had her read the Medication Administration Record (MAR) revealing that Resident # 3 went 24 hours without receiving any Lactulose resulting in the encephalopathy. The</p>	F 309			

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F 309	<p>Continued From page 16</p> <p>physician noted that he had spoken with Resident # 3's regular care nurse and again emphasized the importance of not missing any doses of Lactulose given his TIPS procedure and his high tendency to develop hepatic encephalopathy. The physician added that attempts had been made to contact the medical director of the facility to express the concerns and avoid recurrent facility caused hepatic encephalopathy.</p> <p>The Admission Physicians Order sheet dated January 10, 2014 included Lactulose [20 gm/30 ml] po q 6 hrs at 6 am, 12 noon, 6 pm, 12 midnight start per order at 12 midnight, Rifaximin 550 mg po daily at 9am, Lactulose 20 gm po q 4 hrs as needed for ttrate 3-4 BMs/day.</p> <p>The MAR for 1/10-1/31/2014 documented that Resident #3 had received each ordered dose of Lactulose 30 ml po and Rifaximin 550 mg po since his return on 1/10/2014.</p> <p>An observation was made of Resident # 3 on 1/15/2014 at 3:31 pm lying in his bed awake and alert. When asked if he was doing all right, he replied "I am trying to."</p> <p>On 1/15/2014 at 3:36 pm the nurse manager stated in an interview that Resident #3 had been to the hospital 3 times for end stage liver disease with high ammonia levels. She added that Resident #3 was on Lactulose for the ammonia and had refused a couple of doses. With missing doses she said his ammonia levels go up. She educated him and he had been taking it since he came back. Resident #3 was now on the Lactulose q 6 hours and PRN</p> <p>Resident # 3 was observed during Medication</p>	F 309			

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F 309	<p>Continued From page 17</p> <p>Administration observation on 1/15/2014 at 4:10 pm. He was alert and aware of each medication he received. He kept asking if it was time for his Lactulose. Nurse # 3 explained that his Lactulose was due at 6 pm so it was too early to give it at this time. Asked if he knew why he received the Lactulose, Resident # 3 said yes he did</p> <p>At 9 am on 1/16/2014 Nurse #5 stated in an interview that Resident #3 knows he gets Lactulose and that it is very important for him to get it. If he misses even one dose his ammonia levels go up.</p> <p>On 1/17/2014 at 8:45 am Nurse #5 stated that Resident #3 had never refused his medications when alert. When he got confused that could change. The nurse revealed that on 1/3/2014 and 1/7/2014 when she went to give Resident #3 his morning medications he was so lethargic that he could not take his medications. His medications at 12 noon on 1/3/2014 and at 1pm on 1/7/2014 were also held due to the lethargy and then he was sent to the hospital. Nurse #5 said the MD or NP was there both mornings and assessed Resident #3 and said if he wasn't more alert by afternoon to send him to the hospital. The nurse added that before his last hospitalization they didn't know that missing even one dose of Lactulose would cause an increase in Resident #3's lethargy. They know now and make sure he takes it. Asked what circled initials on a MAR indicated she replied that the medication was not given and they usually noted on the back of the MAR the reason.</p> <p>During an interview on 1/17/2014 at 10:10 am the physician (also the Medical Director for the facility) who sent Resident #3 to the hospital on</p>	F 309		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 346061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/17/2014
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27706		
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F 309	<p>Continued From page 18</p> <p>1/7/2014 stated that she saw him on 1/7/13 for a re-admission note. She was not sure what time she saw Resident #3, but thought it was around noon and the nurse reported that he had not taken his scheduled Lactulose for her due to his lethargy. The physician said when she examined Resident #3, he was limp and very lethargic. She indicated he did not respond at all for her sternal rub. She added that with his advanced liver disease missing 1 or 2 doses of Lactulose would lead to the same effect. Asked when he missed his doses what were her expectations of the nurse, she responded that she expected the nurse to call right away. When Resident #3 was arousable only to sternal rub, she would have expected someone to call the physician service or the physician herself. If she had known he had missed his medications and had lethargy, she would have sent him to the hospital right away.</p> <p>On 1/17/2014 at 11:59 am the physician who sent Resident #3 to the hospital on 1/7/2014 stated in an interview that when she saw him on the morning of 1/7 around 9am, the resident was hard to keep awake. The nurse informed her that the resident had been unable to take his 9 am medications because he was too lethargic. The physician added that she ordered a STAT (immediate) ammonia level with the hopes of getting it back that day. In 2-3 hours when he was still difficult to arouse and she was unable to get the ammonia results back that day, she decided to send him to the hospital. When asked what her expectation was for Resident #3's return from the hospital, she replied that she expected him to receive his evening dose of Lactulose and if there was any doubt to call the physician. On admission the nurse was to call the physician to verify the medications and then fax them to the pharmacy.</p>	F 309			

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F 309	<p>Continued From page 19</p> <p>The physician added that when she re-admitted Resident #3, she had spoken to the nurses about his condition and need for his medications.</p> <p>During an interview on 1/17/2014 at 2:33 pm, the nurse manager stated that if she knew the physician was coming to the facility that day, she waited for the physician to come to the floor to see the patient to inform them about changes. She added that when the nurse told her Resident #3 was lethargic on 1/3 and on 1/7/2014 and she assessed the resident she was not aware that he had missed any doses of his Lactulose. The nurse manager further stated that she didn't check the MAR as she expected her nurses to let her know of missed medications. She said that when the hospital physician called and talked to the nurses, he educated them that this resident could not miss even a single dose of Lactulose due to his advanced liver disease. The nurse manager also said she did not know if the night nurse (11pm to 7am) had given the Lactulose for 12 midnight and 6 am on 1/7/2014.</p> <p>At 3:42 pm on 1/17/2014 Nurse #4 stated in an interview that she admitted Resident #3 on 1/3 and 1/6/2014. When he came in she called the physician service and had his orders verified. The orders were then faxed to the pharmacy. If he didn't have any Lactulose when due, they would have to call the back up pharmacy to get it. Nurse #4 added that Resident #3 had several bottles of Lactulose on hand so he could get it. She said that she gave the 5 pm dose on 1/3/2014, but was late since he had just arrived. The nurse said she doesn't know why she didn't initial the MAR except it was a busy night. Nurse #4 said she gave the 6 pm dose of Lactulose on 1/6/2014, but Resident #3 arrived over an hour after the 5 pm</p>	F 309		

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F 309	Continued From page 20 dose of Rifaximin was due so it wasn't given. Several attempts were made to contact the 11pm to 7am nurse and she was unavailable for an interview. On 1/17/2014 at 4:49 pm the Director of Nurses (DON) was asked what her expectations were of her nurses if a resident had AMS. The DON said she expected the nurse to notify the physician. She indicated that if medications were not available the nurse should call the back up pharmacy. She had no explanation for the missing administration of Lactulose on 1/6/14 at 12 midnight and 1/7/2014 at 6 am. The DON confirmed that circled initials on the MAR indicated a medication was not given. She added that the reason should be documented on the back of the MAR	F 309			
F 312 SS-D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident and staff interviews, the facility failed to shampoo the hair of 1 of 11 sampled residents with skin problems. (Resident #9). Findings included:	F 312	F312 1. Corrective action will be accomplished for the resident found to have been affected by the deficient practice; • Resident #9 hair was washed with the prescribed medicated shampoo. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice; • On 1/17/14 the Director of Health Care Service, Unit Managers, and/or Nurse Managers reviewed the Physician orders to identify residents with medicated shampoo orders.	2/20/14	

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F 312	<p>Continued From page 21</p> <p>Resident #9 was admitted to the facility on 6/18/12 with diagnoses which included: left sided paresis, muscle weakness, and late effect cerebrovascular accident.</p> <p>Review of the Dermatology Consult dated 11/5/13 revealed Resident #9 had atrophy of both forearms with xerosis (dry skin). The Dermatologist concluded the resident's skin may have been photo exacerbated given the presence on the dorsal arms, only. Also, the resident's scalp was scalling with a few erosions. The recommendations were as follows: apply (barrier cream) on dorsal hands and forearms every morning; apply (anti-itch lotion) at night for burning; and, apply (anti-itch lotion) daily for scaly skin on arms. The recommendation for the resident's Seborrheic dermatitis was to wash the resident's scalp with (anti-fungal) shampoo three times each week, leave on ten minutes before rinsing.</p> <p>The review of the Physician's Order dated 11/5/13 revealed that Resident #9 was to have (anti-itch lotion) applied daily to the scaly skin on her arms; and, her scalp was to be washed three times each week with (anti-fungal) shampoo which was to be left on for ten minutes before rinsing.</p> <p>Review of the November 2013 MAR (Medication Administration Record) indicated Resident #9's scalp was washed with the medicated shampoo on 11/7/13 during first shift. There was no other documentation indicating medicated shampoo was used on the resident's hair in November or December 2013.</p> <p>Review of the annual MDS (Minimum Data Set)</p>	F 312	<p>3. Measures put into place or systemic changes made to ensure that the deficient practice will not occur;</p> <ul style="list-style-type: none"> The Director of Health Services, Unit Managers and/or Nursing Managers will review the Medication Administrator record to ensure the medicated shampoos are being completed as ordered. This review will be completed weekly for four weeks, monthly for four months then as recommended by Quality Assurance Committee. The Clinical Competency Coordinator has educated the Licensed Nursing staff on the process of administration of medicated shampoos. License nurse education to be completed 2/16/14. Licensed Nurses who did not attend the education will be educated prior to their next scheduled shift. 		

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F 312	<p>Continued From page 22</p> <p>dated 11/7/13 indicated Resident #9 was cognitively intact and had no skin problems.</p> <p>A review of the Nursing Assistant Care Record indicated Resident #9 was to receive assistance with bathing and to have the use of a special shampoo. The nursing assistants were also to routinely use a barrier cream on the resident's skin.</p> <p>The review of the facility's Shower Schedule indicated Resident #9 was to receive a bed-bath on Tuesdays, Thursdays, and Saturdays between 7:00 am and 3:00 pm.</p> <p>Review of the January 2014 MAR indicated Resident #9's hair was washed with the medicated shampoo during the 3:00pm-11:00pm shift on 01/2/14 through 01/16/14 with the exception of 01/12/14 and 01/13/14.</p> <p>During an observation and interview on 1/16/14 at 2:46 pm, Resident #9 was sitting upright in bed reading. The resident revealed that she preferred and received a bed-bath every morning, but was unsure which shift of nursing assistants was responsible for washing her hair twice a week. The resident stated that she was informed by Staff Nurse #3 that the nursing assistants on first shift were responsible for washing her hair on shower days. Resident #9 indicated her current first shift nursing assistant would wash her hair at least once a week; but, when her current nursing assistant was not working, the replacement nursing assistants would not shampoo her hair and would always inform the resident they (nursing assistants) did not know when the resident's hair was to be shampooed. The resident revealed that she had some sores on her</p>	F 312	<p>4. Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained.</p> <ul style="list-style-type: none"> The Director of Health Care Services will submit the findings of the Medication Administration review to the Quality Assurance / Performance Improvement Committee for review and recommendations monthly . 		

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F 312	<p>Continued From page 23</p> <p>scalp which required a medicated shampoo, so it was important that her hair was washed every few days.</p> <p>During an interview on 01/17/14 at 12:17 pm, Staff Nurse #3 revealed that Resident #9's hair was washed on her shower days which were Mondays, Wednesdays, and Fridays during second shift. She stated that the resident's hair was washed during her bed-baths because the resident did not take showers.</p> <p>During an interview on 01/17/14 at 1:05 pm, the 3rd Floor Unit Coordinator stated when a resident's hair is to be shampooed with a medicated shampoo, the nurse should apply the shampoo to the resident's hair, and then the nursing assistant would wash the resident's hair. After the resident's hair was shampooed, the nurse should sign the MAR.</p> <p>On 1/17/14 at 1:19 pm, NA#1 (Nursing Assistant) revealed that she had worked with Resident #9 often for approximately one year and had given the resident bed-baths. She revealed that the resident would sometimes request and the nursing assistants would wash her hair with the shampoo supplied by the resident's daughter. NA#1 stated that the nurses had never given her any special shampoo to use when washing the resident's hair.</p> <p>During an interview on 1/17/14 at 3:42 pm, the DON (Director of Nursing) revealed because of her back pain, Resident #9 preferred bed-baths rather than showering. The DON revealed that each resident received a shower three times each week (more often if requested), but if a resident preferred a bed-bath then it would also be</p>	F 312			

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F 312	Continued From page 24 provided three times each week (more often if requested). The DON stated that a resident's hair was typically washed on shower days.	F 312		
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to administer the ordered medications of Lactulose (an ammonia detoxicant) and Rifaximin (for hepatic encephalopathy), which resulted in a significant medication error for 1 of 5 residents (Resident #3). Findings included: Resident # 3 was admitted to the facility on 12/23/2013 with re-admissions on 1/2/2014, 1/6/2014, and 1/10/2014. Diagnoses included decompensated liver cirrhosis secondary to Hepatitis C complicated by portal hypertension, anemia, diabetes mellitus type 2 on insulin, and stage III chronic kidney disease. Hospital records reviewed documented that in November 2013 Resident # 3 had a Transjugular Intrahepatic portosystemic shunt (TIPS) which was a procedure to create new connections between two blood vessels in the liver due to severe liver problems. Physician orders reviewed found that on admission 12/23/2013 Resident # 3 was receiving 30 ml (milliliters) (20 g) (grams) of Lactulose and	F 333	1. Corrective action will be accomplished for the resident found to have been affected by the deficient practice; <ul style="list-style-type: none"> Resident no longer resides in the facility 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice; <ul style="list-style-type: none"> On January 17, 2014 The Director of Health Services, Unit Managers, Unit Coordinator and Nursing Supervisors have reviewed all Medication Administration records with physicians notification regarding residents who have refused two consecutive doses of vital medications per facility policy. 3. Measures put into place or systemic changes made to ensure that the deficient practice will not occur; <ul style="list-style-type: none"> On January 17, 2014 Clinical Competency Coordinator and/or Nursing Managers has educated Licenses Nurses on Physician Notification related to the Medication Administration Protocol that states Physician would be notified after two consecutive doses of a vital medication has been missed. 	2/20/14

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F 333	<p>Continued From page 25</p> <p>Rifaximin 560 mg (milligrams) bld (two times a day).</p> <p>The MAR for December 23-27, 2013 documented that Resident #3 received each ordered dose of Lactulose 30 ml po and Rifaximin 500 mg po starting the night of 12/23/2013 and ending with the last dose the morning of 12/27/2013 before going to the hospital.</p> <p>Physician Progress notes for 12/27/2013 were reviewed and documented in part the following: Initially resident was able to sit up in bed and communicate with staff. Today It was reported that he had been presenting with increased lethargy and somnolence since 2 days ago. His ammonia level yesterday was 177 (normal 20 -70). On eval very lethargic. Will transfer to the hospital for further management.</p> <p>Review of a hospital Discharge Summary dated 1/2/2014 found that Resident # 3 had been admitted on 12/27/2013 with altered mental status secondary to hepatic encephalopathy. Resident #3 's ammonia level checked at the facility was 177. The summary noted that the encephalopathy gradually occurred despite receiving the ordered doses of Lactulose 20 gm in 30 ml bid and Rifaximin 550 mg bid. On discharge the Lactulose was increased from bid to three times a day (tid) and Resident #3 was counseled on the importance of taking the Lactulose titrated to 2-3 bowel movements per day. (The liver normally breaks down ammonia, but in liver disease such as cirrhosis the blood may bypass the liver, allowing this poisonous substance to pass to the brain. Here it can impair brain function, causing confusion, drowsiness and finally coma. Per the 2013 Lippincotts Nursing</p>	F 333	<ul style="list-style-type: none"> The policy has been reviewed by the corporate policy committee Change of Condition Care Guard Program: protocol that states" the Physician would be notified after two consecutive doses of a vital medication has been missed". The clinical Competency Coordinator / DHS and Nursing Supervisors began education on 1/17/14 through 1/26/14 for Licensed Nurses related to the protocol, Licensed Nurses not in attendance will be educated prior to their next scheduled shift. Physician notification of after two consecutive doses of a vital medication has been missed has been added to the general orientation of Licensed Nurses upon hire. The Licensed Nurses complete a shift to shift Medication Administration Record review to identify medications that have not been administered to the residents, documentation on back of MAR to state reason for circled or omitted medication, to validate that the Physician has been notified The Director of Health Services and/or Nurse Managers review the Licensed Nurse shift to shift review weekly to validate the completion of the review, documentation on back of MAR to state reason for omitted medication and that the notification to the physician has been completed. This review will be completed weekly for four weeks, the monthly for 3 months then as directed by the Quality Assurance Committee. 		

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F 333	<p>Continued From page 26</p> <p>Drug Handbook Lactulose causes the migration of blood ammonia into the colon trapping and expelling it in the feces. Rifaximin is used for reduction of recurrence of hepatic encephalopathy in patients with advanced liver disease.)</p> <p>Physician orders dated January 2, 2014 Lactulose 30 ml po (by mouth) tid at 9am, 1pm, 5pm and Rifaximin 550 mg po bid at 9am and 5pm.</p> <p>The Medication Administration Record (MAR) for January 2-3, 2014 was reviewed. For 1/2/2014 the MAR had no initials indicating administration of Lactulose 30 ml po at 5 pm and the initials were circled at 9 am and 1 pm on 1/3/2014. Rifaximin 550 mg po bid had no initials on 1/2/2014 at 5 pm and the initials were circled for 9 am on 1/3/2014. There was no documentation on the back to indicate the reason for missed doses.</p> <p>A review of Nurses' notes found that Resident # 3 arrived at the facility on 1/2/2014 around 5:45 pm, was able to verbalize needs, and had no pain or distress. Medications were verified by the nurse practitioner (NP) and faxed to the pharmacy.</p> <p>On 1/3/2014 the Nurses' notes indicated that at 2 am Resident # 3 was alert and oriented, able to make needs known. At 8 am the nurse manager noted that during rounds Resident #3 was found to be very lethargic and unable to arouse. "Will have Dr. to see this am." At 9 am the note indicated the physician was there to see the patient and new orders were written. At 2 pm the note indicated there was an order to send Resident #3 to the hospital and at 3 pm 911 was there to transport.</p>	F 333	<ul style="list-style-type: none"> The root cause analysis was completed by Dr. Jackson on February 27, 2014 thru March 1, 2014. Existing policy and procedures for when to notify a physician and facility management, including staff responsibility on a significant change in condition (Uni-Guard) in order to strengthen this program we retrained licensed and non-licensed by March 10, 2014. In order to strength the ongoing education of licensed personnel, additional training and follow up testing to licensed staff was provided to include bowel sounds, heart sounds, fluid volume and cardiac assessment was completed as of March 10, 2014. <p>4. Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained.</p> <ul style="list-style-type: none"> The Director of Health Services will present the findings of the Medication Administration Review with physician notification to the Quality Assurance and Performance Improvement Committee monthly for review and recommendation for revisions. The Clinical Competency coordinator will present the results of the educated related to training and follow up testing to the Quality Assurance / Performance Improvement committee for review, recommendations and revision. 	

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F 333	<p>Continued From page 27</p> <p>Physician's Progress Note of 1/3/2014 Transition into care was reviewed for the following information. Lactulose was increased to tid ... On eval today pt (patient) was resting in bed, asleep, difficult to arouse, unable to keep eyes open or answer simple questions. According to daytime nurse, he had been like this all morning today and was not able to eat lunch due to AMS (altered mental status). Nighttime nurse reported he was awake and alert "Since he failed to wake up and become more interactive as was his baseline and requested blood work won't be available today, will transfer back to the hospital."</p> <p>A review of the hospital Discharge Summary dated 1/6/2014 noted that Resident # 3 was admitted to the hospital on 1/3/2014 with hepatic encephalopathy with altered mental status and somnolence. His ammonia level was on admission was 181. The summary indicated that it was thought the cause was possibly due to missed doses of Lactulose. After being given Lactulose in the hospital by a nasal gastric (ng) tube over 12 hours, Resident # 3 was back to his baseline. On discharge the Lactulose was being given by mouth and was to be given q (every) 6 hours. Instructions noted the Lactulose was to be given for a goal of 3-4 bowel movements a day. If the scheduled dose was not sufficient to achieve 3-4 bowel movements a day extra doses could be given q 4 hours.</p> <p>Physician orders dated January 6, 2014 reviewed contained Lactulose 30 ml po q 6 hrs at 6 am, 12 noon, 6 pm, and 12 midnight and Rifaximin 550 mg po bid at 9am and 5 pm. Also ordered was Lactulose [20 gm/30 ml] po q 4 hrs as needed titrate to 3-4 bowel movements per day.</p>	F 333			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/17/2014
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
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F 333	<p>Continued From page 28</p> <p>The MAR for January 6-31, 2014 revealed that on 1/6/2014 Lactulose 30 ml po was initiated given at 6 pm, had no initials for 12 midnight or 6 am, and had circled initials for 12 noon. The Rifaximin 550 mg po bid had no initial for 5 pm on 1/8/2014 and a circled initial for 9 am on 1/7/2014. The back of the MAR documented that at 9 am and 12 noon all meds were held due to resident very drowsy at 9 am and unable to rouse at noon. The MAR had not documented any PRN (as needed) doses of Lactulose given.</p> <p>The Nurses' notes for 1/6/2014 documented that Resident #3 arrived at the facility around 6 pm, was alert and responsive with no complaints of pain or discomfort.</p> <p>On 1/7/14 at 2 am the notes indicated no distress was observed for Resident #3. At 8 am Resident #3 was assessed by the nurse manager and aroused enough to open eyes with sternal rub being done and moaned a little. Will continue to monitor and have MD (physician) to see patient today. At 12pm the nurse manager assessed Resident #3 and found no changes. At 2:30 pm the MD was with the patient and orders given to send the resident to the hospital. At 3:50 pm 911 was called and at 4:15 pm Resident #3 was transported to the hospital.</p> <p>A review of the Physician's 1/7/2014 Transition into care note revealed the following. After hospitalization the Lactulose was titrated up to q 6 hrs. He was transferred back to the facility on 1/6/2014 and it is not clear whether he tolerated his oral medications. Today on my exam he was not responding to stimulation, painful stimulation, or sternal rub. Staff stated resident not able to take medications due to somnolence, decreased</p>	F 333			

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F 333	<p>Continued From page 29</p> <p>level of consciousness. Patient will be transferred to the hospital via EMS (emergency medical services).</p> <p>The hospital Discharge Summary dated 1/10/2014 for an admission on 1/7/2014 was reviewed. The Summary indicated that Resident # 3 was again admitted for portosystemic encephalopathy. His ammonia level was 163. Search for the cause of the recurrent hepatic encephalopathy "revealed medication noncompliance by the facility." The Summary added that the physician spoke with the 7 am to 3 pm nurse and had her read the Medication Administration Record (MAR) revealing that Resident # 3 went 24 hours without receiving any Lactulose resulting in the encephalopathy. The physician noted that he had spoken with Resident # 3's regular care nurse and again emphasized the importance of not missing any doses of Lactulose given his TIPS procedure and his high tendency to develop hepatic encephalopathy. The physician added that attempts had been made to contact the medical director of the facility to express the concerns and avoid recurrent facility caused hepatic encephalopathy.</p> <p>Physician orders reviewed for January 10, 2014 included Lactulose [20 gm/30 ml] po q 6 hrs at 6 am, 12 noon, 6 pm, 12 midnight start per order at 12 midnight, Rifaximin 550 mg po daily at 9am, Lactulose 20 gm po q 4 hrs as needed for titrate 3-4 BMs/day.</p> <p>The MAR for January 10 - 31, 2014 documented that Resident #3 had received each ordered dose of Lactulose 30 ml po and Rifaximin 550 mg po since his return on 1/10/2014.</p>	F 333			

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F 333	<p>Continued From page 30</p> <p>On 1/15/2014 at 3:36 pm the nurse manager stated in an interview that Resident #3 had been to the hospital 3 times for end stage liver disease with high ammonia levels. She added that Resident #3 was on Lactulose for the ammonia and had refused a couple of doses. With missing doses she said his ammonia levels go up. She educated him and he had been taking it since he came back. Resident #3 was now on the Lactulose q 6 hours and PRN.</p> <p>Resident # 3 was observed during Medication Administration observation on 1/15/2014 at 4:10 pm. He was alert and aware of each medication he received. He kept asking if it was time for his Lactulose. Nurse # 3 explained that his Lactulose was due at 6 pm so it was too early to give it at this time. Asked if he knew why he received the Lactulose, Resident # 3 said yes he did</p> <p>On 1/17/2014 at 8:45 am Nurse #5 stated that Resident #3 had never refused his medications when alert. When he got confused that could change. The nurse revealed that on 1/3/2014 and 1/7/2014 when she went to give Resident #3 his morning medications he was so lethargic that he could not take his medications. His medications at noon on 1/3/2014 and at 1pm on 1/7/2014 were also held due to the lethargy and then he was sent to the hospital. The nurse added that before his last hospitalization they didn't know that missing even one dose of Lactulose would cause an increase in Resident #3's lethargy. They know now and make sure he takes it. Asked what circled initials on a MAR indicated she replied that the medication was not given and they usually noted on the back of the MAR the reason.</p>	F 333			

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F 333	<p>Continued From page 31</p> <p>During an interview on 1/17/2014 at 10:10 am the physician (also the Medical Director for the facility) who sent Resident #3 to the hospital on 1/7/2014 stated that she saw him on 1/7/13 for a re-admission note. She was not sure what time she saw Resident #3, but thought it was around noon and the nurse reported that he had not taken his scheduled Lactulose for her due to his lethargy. The physician said when she examined Resident #3, he was limp and very lethargic. She indicated he did not respond at all for her sternal rub. She added that with his advanced liver disease missing 1 or 2 doses of Lactulose would lead to the same effect. Asked when he missed his doses what were her expectations of the nurse, she responded that she expected the nurse to call right away. When Resident #3 was arousable only to sternal rub, she would have expected someone to call the physician service or the physician herself. If she had known he had missed his medications and had lethargy, she would have sent him to the hospital right away. The physician further stated that she had returned the hospital physician 's call and was forwarded to another number. She left her number. She indicated that she and the hospital physician spoke on 1/16/2014 and he said all had been worked out.</p> <p>On 1/17/2014 at 11:59 am the physician who sent Resident #3 to the hospital on 1/7/2014 stated in an interview that when she saw him on the morning of 1/7, the resident was hard to keep awake. The physician added that she ordered a STAT (immediate) ammonia level with the hopes of getting it back that day. In 2-3 hours when he was still difficult to arouse and she was unable to get the ammonia results back that day, she decided to send him to the hospital. When asked</p>	F 333			

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F 333	<p>Continued From page 32</p> <p>what her expectation was for Resident #3's return from the hospital. She replied that she expected him to receive his evening dose of Lactulose and if there was any doubt to call the physician. On admission the nurse was to call the physician to verify the medications and then fax them to the pharmacy. The physician added that when she re-admitted Resident #3, she had spoken to the nurses about his condition and need for his medications.</p> <p>The nurse manager stated in an interview on 1/17/2014 at 2:33 pm that when the nurse told her Resident #3 was lethargic on 1/3 and on 1/7/2014 and she assessed the resident she was not aware that he had missed any doses of his Lactulose. The nurse manager further stated that she didn't check the MAR as she expected her nurses to let her know of missed medications. She said that when the hospital physician called and talked to the nurses, he educated them that this resident could not miss even a single dose of Lactulose due to his advanced liver disease. The nurse manager also said she did not know if the night nurse (11pm to 7am) had given the Lactulose for 12 midnight and 6 am on 1/7/2014.</p> <p>On 1/17/2014 at 3:42 pm Nurse #4 said that she gave the 5 pm dose of Lactulose on 1/3/2014, late since Resident #3 had just arrived. The nurse said she doesn't know why she didn't initial the MAR except it was a busy night. Nurse #4 said she gave the 6 pm dose of Lactulose on 1/6/2014, but Resident #3 arrived over an hour after the 5 pm dose of Rifaximin was due so it wasn't given.</p> <p>Several attempts were made to contact the 11pm to 7am nurse and she was unavailable for an</p>	F 333			

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F 333	Continued From page 33 Interview.	F 333			
F 425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, pharmacy</p>	F 425	<p>1. Corrective action will be accomplished for the resident found to have been affected by the deficient practice;</p> <ul style="list-style-type: none"> Resident #3 was given Novolog as ordered. Novolog Insulin was ordered from the pharmacy and received. <p>2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice;</p> <ul style="list-style-type: none"> On 1/17/14 Director of Nursing, Unit Manager and Nursing Management has audited the medication carts to validate that each resident prescribed insulin has the insulin available. 	2/20/14	

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F 425	<p>Continued From page 34</p> <p>and staff interviews, the facility failed to obtain an ordered insulin from the pharmacy for 1 of 5 residents observed during a medication pass (Resident #3). Findings included:</p> <p>Resident # 3 was admitted to the facility on 12/23/2013 with re-admissions on 1/2/2014, 1/6/2014, and 1/10/2014. Diagnoses included decompensated liver cirrhosis secondary to Hepatitis C complicated by portal hypertension, anemia, diabetes mellitus type 2 on insulin, and stage III chronic kidney disease.</p> <p>Physician orders reviewed found that on admission 12/23/2013 Resident # 3 was receiving Humulin N insulin 12 units SQ (subcutaneous) before breakfast and 8 units SQ before dinner.</p> <p>Review of Medication Administration Records (MARS) from admission on 12/23/2014 through 1/17/2014 indicated that the Humulin N insulin was given as ordered.</p> <p>Review of physician's orders also found an order dated 1/14/2014 for facility sliding scale protocol with SSI (sliding scale) Novolog Accuheck q (every) ac (before meals) and hs (bedtime). A fax transmission verification report indicated this order was faxed to the pharmacy on 1/14/2014 at 1:22 pm.</p> <p>Resident # 3 was observed during Medication Administration observation on 1/15/2014 at 4:10 pm. He was alert and aware of each medication he received. An accuheck at this time indicated Resident #3 required an injection of 6 units Novolog insulin for a blood sugar of 307 in addition to his scheduled 8 units of Humulin N insulin. The Humulin N insulin for Resident #3</p>	F 425	<p>3. Measures put into place or systemic changes made to ensure that the deficient practice will not occur;</p> <ul style="list-style-type: none"> On 1/17/14 the Clinical Competency Coordinator/ Nursing Management began educating the Licensed Staff on medication ordering with emphasis on insulin. Licensed Nurses will be educated prior to their next scheduled shift. The Unit Managers, Nursing Manager and/or Director of Health Services will complete a medication cart audit related to insulin's to validate medications are available for use, this will be completed weekly for four weeks then monthly thereafter. The Director of Health Services will trending the weekly medication cart audits and present to the Quality Assurance Committee monthly. <p>4. Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained.</p> <ul style="list-style-type: none"> The Director of Nursing will present the findings of the Medication Cart audit monthly to the Quality Assurance and Performance Improvement Committee for review and revision as needed. 		

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F 425	<p>Continued From page 35</p> <p>was present in the medication cart. There was no Novolog Insulin for him in the medication cart. Nurse #4 went to each of the 3 floors ' E-kits (emergency insulin kits) finding no Novolog insulin. She then placed a call to the physician ' s service. At this time the Director of Nurses (DON) was speaking by phone to the consultant pharmacist. She told Nurse #4 that a blood sugar of 307 requiring 6 units of Novolog Insulin could be considered an emergency and since it was not a narcotic it would be acceptable to use another resident ' s insulin. Nurse # 4 was observed drawing up Novolog insulin from another resident ' s vial and giving it SQ to Resident #3. The Novolin insulin was drawn up into a separate syringe and also given SQ to him.</p> <p>On 1/15/2014 at 4:30 pm the medication reconciliation from the above observation found the MAR documented that Resident #3 had an accuheck on 1/15/2014 before breakfast and did not require any insulin and an accuheck before lunch that yielded a need for 2 units of Novolog insulin and was initiated as given.</p> <p>The DON was asked on 1/15/2014 4:35 pm what they used for the insulin needed at lunch time. She responded that the day nurse had called the back up pharmacy and the insulin would be sent that night. The day nurse also used another resident ' s insulin.</p> <p>On 1/16/2014 at 3:55 pm Nurse #4 stated in an interview that when insulin was taken out of the E-kit (emergency kit) they should fill out a form and fax it to the pharmacy. She indicated that some nurses waited until the E-kit was empty before faxing to the pharmacy. Nurse #4 showed me the book of forms and said the pink copy</p>	F 425			

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F 425	<p>Continued From page 36</p> <p>stayed in the book, and the yellow copy went with the kit. Asked if there was more than 1 of each type of insulin in the E-kit she responded no only one of each. The most recent date on the pink form in the book was during 10/2013. Asked who was responsible for refilling the E-kits, she replied the pharmacy was. Nurse #4 was asked what was the procedure for getting newly ordered medications? She replied the order was verified by the physician or nurse practitioner (NP) and then faxed to the pharmacy. Pharmacy made one delivery a day at night. If medications were needed before the delivery time, they called the back up pharmacy. She added that even then it might be hours before the medication arrived. The nurse indicated they had problems with the pharmacy saying they never received the fax even when the facility received a verification of receipt. She further stated that she has faxed orders 3 times, called the pharmacy and been told the medications were being sent and the facility did not receive them. When asked what she did when this happened, she indicated that she notified the nurse manager and the DON. Nurse #4 produced a transmission verification slip indicating that Resident #3's Novolog SSI order was faxed to the pharmacy on 1/14/2014 at 1:22 pm.</p> <p>At 12:49 pm on 1/17/2014 the facility pharmacy was called. The pharmacist stated that when they received a faxed order, it was processed and sent out on the next delivery. Deliveries occurred once a day going out around 8 pm. If a fax was received after 5pm, it was processed the next day and went out in the next day's delivery. If a facility needed a medication before the scheduled delivery they needed to call the 24 hour back up pharmacy. E kits were rotated weekly by courier.</p>	F 425			

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F 425	<p>Continued From page 37</p> <p>The courier would take the new one out and was supposed to bring the empty one back. Sometimes the courier took longer to bring the old one back and they would run out of kits, so they had to wait until the empty kit came back in. When insulin was removed from a kit, a billing slip was filled out and put in the kit or faxed for billing purposes. The pharmacist checked the pharmacy fax records and said they received the fax for Resident #3 's new sliding scale Novolog on 1/15/2014 at 10:55 am. It would have gone out the night of 1/15/2014. They had the signed slip indicating that it was delivered on 1/15/2014.</p> <p>At 1:10 pm on 1/17/2014 the two main back up pharmacies for the facility were called and asked if they had any requests in the last month for Novolog insulin for Resident #3. The first pharmacy ran a usage report for Novolog insulin for the last month and a half and had no requests for Novolog for any resident at the facility. The second pharmacy had no requests for insulin for Resident #3 during 1/2014. The pharmacist said the last request for any medications for Resident #3 was 12/23/2013.</p> <p>In an interview on 1/17/2014 at 2:33 pm the nurse manager said when a physician order was written, the nurse who took the order off the order sheet or took the telephone or verbal order, faxed it to the pharmacy and tried to make sure the medication was received. The nurse manager said there had been a lot of issues with them faxing orders to the pharmacy and the pharmacy saying they never received the orders. She had faxed orders and called the pharmacy later and the pharmacy said they did not receive the fax.</p> <p>On 1/17/2014 at 4:49 pm the DON stated in an</p>	F 425			

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F 425	Continued From page 38 interview that when orders were received for medications, they were faxed to the pharmacy by the nurse taking off the order. If the medications were not received, their 24 hour back up pharmacy should be called. However, the DON added that sometimes the back up pharmacy said they didn't have the medication or would tell them to call their pharmacy if during business hours. She had spoken with the pharmacy consultant about issues getting medications and the consultant pharmacist assisted with the problems. Nurses have been instructed if medications were not received to call the back up pharmacy. She further said that she was going to have to have a meeting with the pharmacy manager and the administrator to discuss the problems they are having getting medications.	F 425			