STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345492	A. BUILDING _____ B. WING _____	C 02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC STATE VETERANS NURSING HOME	**214 COCHRAN AVENUE FAYETTEVILLE, NC 28301**

(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 000	INITIAL COMMENTS On-site complaint investigation was from 2/6/15 through 2/9/15. The exit date was changed to 2/19/15 due to an interview required and completed on 2/19/15 for the tags cited during the investigation.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 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). 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. The facility must record and periodically update the address and phone number of the resident's	F 157		3/20/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/06/2015

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F 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, the physician ' s office nurse, the resident ' s Responsible Party and the physician the facility notified the physician ' s office nurse of abnormal lab results but the facility failed to follow-up when they did not hear from the physician for 1 of 3 residents reviewed (Resident #3) resulting in the resident being admitted to the hospital with severe dehydration. The facility also failed to notify the Responsible Party of abnormal lab results and worsening of a pressure ulcer for 1 of 3 sampled residents (Resident #3). The findings included: 1a. Resident #3 was originally admitted to the facility on 9/18/14 and had diagnoses that included Advanced Dementia, Generalized Weakness and Difficulty Walking. Record review revealed laboratory test results dated 11/15/14 that revealed the resident ' s Blood Urea Nitrogen (BUN) was 16 (Normal range 6-23) and Creatinine was 0.89 (Normal range 0.50-1.10). A BUN and Creatinine reflect how well the kidneys are working. Review of the clinical record revealed physician ' s orders dated 1/27/15 for a complete blood count (CBC), complete metabolic panel (CMP) a urinalysis and a Chest X-ray. A radiology report dated 1/28/15 revealed a possible right lung base infiltrate (possible pneumonia). At the bottom of the report was a	F 157	This plan of correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements by State and Federal Laws. F157D 1. A. For Resident #3: The corrective action was not done as the resident is currently in the hospital. B. The Responsible Party of residents with critical labs/labs with orders for changes in treatment and/or worsening of pressure ulcers will be notified and resident's physician/physician extender will be notified of critical/abnormal labs. C. A 100% audit was completed on labs drawn on 1/27/15 to verify all abnormal lab results were reported to the physician and responsible party. D. A 100% audit will be completed on labs drawn from 1/28/15 to 2/9/15 for active residents, to verify all abnormal labs were reported to the physician and all critical labs/labs with orders for changes in treatment were reported to the responsible party. E. A 100% audit was completed to verify that the responsible party was notified of any worsening pressure ulcers.	

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F 157	Continued From page 2 hand written note that read: " Faxed & called in 1/29/15 " and followed by the initials of the person who faxed and called in the report. A nurse ' s note dated 1/29/15 read: " New orders received via telephone r/t (related to) CXR (chest x-ray) results. There was a hand written physician ' s telephone order (TO) dated 1/29/15 for an antibiotic daily for 7 days with the following signature: " T.O. Name of physician/name of physician ' s nurse/name of nurse at facility that took the order. " A laboratory (lab) results sheet revealed blood for a Complete Blood Count and Comprehensive Metabolic Panel (CMP) was collected on 1/28/15 at 6:00 AM. The results included a white blood cell count (WBC) of 19.5H (H meaning high). The normal range was listed as 4.0-10.5. A high WBC indicates infection. The BUN was 85H (normal range 6-23). The Creatinine was 1.66H (normal range 0.50-1.10). An elevated BUN and Creatinine could indicate dehydration. The lab sheet revealed the labs were printed in the facility on 1/29/15 at 5:18 AM. There was information stamped on the sheet that read: " FAXED JAN 29 2015. " There was not a time or initials of the person who faxed the information. There was no documentation in the nurse ' s notes of the abnormal lab results or that the physician was notified of the results. There were no additional physician ' s orders related to the lab results after the antibiotic order dated 1/29/15. There were no physician ' s progress notes from 1/27/15 until 2/3/15 when the physician gave an order to send the resident to the hospital. The Physician caring for the resident in the facility stated in an interview on 2/10/15 at 3:55 PM that he must have seen the lab results because he	F 157	2. A. New process for notification of physician concerning abnormal/critical labs: Nursing will no longer call the physician's office nurse concerning abnormal/critical labs. When there is a critical lab the physician will be notified on the day the results were received for additonal orders if indicated. When there is an abnormal lab the physician/physician extender will be notified by the next day for additional orders if indicated. The Nurse who notified the physician of the critical/abnormal labs will document on the lab result the physician's response. The labs with the documented responses will then be faxed to the physician/physician extender for further review. B. All nurses will be in-serviced and new nursing employees will be in-serviced prior to providing direct resident care concerning reporting critical/abnormal labs to the physician and all critical labs/labs with orders for changes in treatment and/or worsening in pressure ulcers are reported to the responsible party. C. Nurses who are non-compliant with reporting abnormal labs to the physician and all critical labs/labs with orders for changes in treatment and worsening in pressure ulcers are reported to the responsible party will be counseled by nursing administration and receive additional education when indicated.	

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F 157	Continued From page 3 gave an order for antibiotics for the high white count. The Physician stated he could not recall what his response to the elevated BUN and Creatinine was and would need to review the medical record. In a separate interview on 2/11/15 at 2:08 PM the Physician stated he could not find any physician documentation regarding the resident ' s elevated BUN and Creatinine. The Physician stated he felt like it was addressed because he had put the resident on an antibiotic for the high white count. The Physician stated for the resident ' s elevated BUN and Creatinine he normally would have told the staff to increase fluids by mouth or start intravenous (IV) fluids and if that did not work would send the resident to the hospital. When asked if he was aware the resident was not drinking very well the Physician stated he was aware the resident refused care and medications. The physician was asked the question a second time but did not answer the question. On 2/11/15 at 2:55 PM an interview was conducted with the physician ' s office nurse. The Nurse stated her job was to answer phone calls, receive faxed information and she relayed messages to the physician. The Nurse stated she had documentation for all the calls she received and the physician ' s response to the calls. The Nurse stated she received a call from the facility on the morning of 1/29/15 regarding an abnormal chest x-ray. The Nurse stated she read the results of the x-ray to the physician and at 4PM on 1/29/15 she called the facility with an order for an antibiotic. The Nurse stated she did not receive any phone calls from the facility on 1/29/15 or 1/30/15 with regards to abnormal lab work. The Nurse stated the antibiotic was ordered	F 157	3. A. A monitoring form has been developed for the notification of the physician concerning abnormal labs and notification of the responsible party of critical labs/labs with orders for changes in treatment and new/worsening in pressure ulcers. The monitoring will be completed by the Interdisciplinary Team member(s). The monitoring will occur as follows: At least 3 patients per unit (total of 9 patients) with critical labs/labs with orders for changes in treatments will be monitored as stated below along with notification of the physician/physician extender for critical labs and abnormal labs. Notification of the responsible party of critical labs/labs with orders for changes in treatment for a duration of: 4 times per week for 4 weeks 3 times per week for 4 weeks 2 times per week for 4 week 1 time per week for 4 weeks Then monthly for 3 months or until major compliance by the Quality Assurance Committee. At least 3 patients per unit (total of 9 patients) with new pressure ulcer/worsening pressure ulcers will be monitored for notification of responsible party for a duration of: 4 times per week for 4 weeks 3 times per week for 4 weeks 2 times per week for 4 week 1 time per week for 4 weeks Then monthly for 3 months or until major compliance by the Quality Assurance	

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F 157	Continued From page 4 due to the abnormal chest x-ray. An interview was conducted with the Director of Nursing (DON) and the C Wing Unit Coordinator on 2/11/15 at 3:40 PM. The DON stated critical lab results were to be faxed and then called to the physician ' s office during office hours and a call directly to the physician when outside office hours. The DON stated the lab results should have been called to the physician. Nurse #1 stated in an interview on 2/11/15 at 4:05 PM that she worked on the 7AM-3PM shift on 1/29/15. The Nurse stated she faxed the chest x-ray report and called the office regarding the abnormal report. The Nurse was observed to review the lab results printed at the facility on 1/29/15. The Nurse stated she never saw the lab work and would have definitely called the physician ' s office with the high BUN and Creatinine had she seen the lab results. There was no documentation in the nurse ' s notes the Responsible Party (RP) was notified that lab work had been ordered or of the abnormal lab results. Nurse #2 stated in an interview on 2/12/15 at 8:14 AM that he mostly worked with the QI (Quality Improvement) Nurse, made sure the lab book was up to date and printed off all the labs in the morning. The Nurse stated he stamped all the labs with a faxed stamp that included the date. The Nurse stated he could go to the computer and print all unprinted labs at one time. The Nurse stated on the morning of 1/29/15 he printed off 31 lab results and put them all in the fax machine at one time and faxed them to the physician ' s office. The Nurse stated he usually put all the lab results for each hall together and would give to the nurse on the hall. The Nurse	F 157	Committee. 4. The Interdisciplinary Team member (Unit Managers, RN, Clinical Competency Coordinator, RN, Wound Care Nurse, Quality Assurance Coordinator, RN, Director of Nursing, RN, and/or Administrator)will review notification to responsible party and notification to physician/extender. Results of monitoring with tracking and trending will be reported by the Quality Assurance Coordinator (RN) monthly to the Quality Assurance Committee for recommendations and suggestions for improvements or changes.	

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F 157	Continued From page 5	F 157		

stated he did not do anything with the labs except fax them to the physician ' s office. The Nurse stated he did not remember what he did with the labs on the morning of 1/29/15. The Nurse stated he was aware the nurses were supposed to call critical labs to the physician but the nurse on the hall did this. The Nurse could not explain what happened to the labs or who he gave them to on the morning of 1/29/15.

The DON stated in an interview on 2/12/15 at 2:30 PM she spoke with the nurse at the physician ' s office and asked her to fax to the facility any labs she had in the system for Resident #3. The DON stated the labs she received revealed the CBC and CMP results received on 1/29/15 were faxed to the physician ' s office on 1/29/15 at 7:42 AM. The DON stated the staff should have made a phone call to the physician ' s office regarding the abnormal lab results.

The DON stated in an interview on 12/12/15 at 4:45 PM the physician wanted abnormal lab results to be faxed to the nurse in his office followed-up by a phone call and the nurse relayed the lab results to the physician who would give the nurse orders, if any and the nurse called the order to the facility.

There was a physician ' s order dated 2/3/15 at 1:00 PM to Discharge the resident to the hospital due to unable to arouse.

Review of the hospital Admission History and Physical dated 2/3/15 revealed the following: " In the ER (Emergency Room) blood pressure of 60s/50, heart rate 100 and temperature 95.6. Breathing and oxygen saturation were normal but

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F 157	Continued From page 6 was found to be very dehydrated. The family still wants full code for this patient so patient will go to the ICU (intensive care unit) for further management. Physical Examination: General: Patient is now awake, following simple commands and looks very dehydrated. Laboratory Data: WBC (serum white blood cell count) 27,000, sodium 146, potassium 5.3, chloride 111, BUN 101, creatinine 3.6. Urinalysis: 1+ blood, trace of ketones, 3+ leukocyte esterase, WBC more than 180, RBC 120, 3+ bacteria. Chest x-ray unremarkable. Assessment: 1. Altered Mental Status and is lethargic possibly secondary to severe septic shock with hypotension, lactic acidosis and leukocytosis. 2. Possibly the source of infection is urinary tract. 3. Acute renal failure, possibly from septic shock, dehydration and lack of oral intake. 4. Source of infection possibly the sacral ulcer as well as right hip decubitus ulcer. Will give IV fluids. Patient responded to the IV fluids that were given in the ER. " Hospital records revealed 2 blood cultures and cultures of the pressure ulcers on the sacrum and buttocks were collected on 2/3/15 while the resident was in the Emergency Department. Culture results of the pressure ulcers were reported on 2/5/15 and showed moderate to heavy growth of normal skin flora. Hospital records revealed on 2/6/15 the resident underwent a surgical procedure for debridement of the sacral ulcer including skin, subcutaneous tissues, muscle and fascia that measured 11cm by 11cm by 3cm and debridement of the right hip decubitus including skin and subcutaneous tissues that measured 4cm by 3cm by 2cm with wound vac (vacuum) placement. The 2 blood cultures were reported on 2/8/15 that showed no growth at 5 days.	F 157		

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1b. Resident #3 was originally admitted to the facility on 9/18/14 and had diagnoses that included Advanced Dementia, Generalized Weakness and Difficulty Walking.

Review of the clinical record revealed physician ' s orders dated 1/27/15 for a complete blood count (CBC) and a complete metabolic panel (CMP). There was no documentation in the nurse ' s notes that the RP was notified.

Review of laboratory (lab) studies drawn on 1/28/15 included a complete blood count and a comprehensive metabolic panel. There was no documentation in the nurse ' s notes the Responsible Party (RP) was notified.

Review of the lab results printed in the facility on 1/29/15 at 5:18 AM revealed a high serum white blood cell (WBC) count and elevated Blood Urea Nitrogen (BUN) and Creatinine. A high WBC would indicate possible infection. A high BUN and Creatinine could indicate dehydration. There was no documentation the RP was notified.

The Unit Coordinator of the C-Wing stated in an interview on 2/10/15 at 3:05 PM the RP should be notified when lab work was ordered, the results of the lab work and any change in the resident ' s condition.

Nurse #1stated in an interview on 2/11/15 at 4:05 PM that she worked the 7AM to 3PM shift on 1/29/15. The Nurse was observed to review the lab results printed in the facility on 1/29/15 at 5:18 AM. The Nurse stated she never saw the lab results.

Nurse #2 stated in an interview on 12/12/15 at

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8:14 AM that he worked mostly with the QI (Quality Improvement) Nurse and made sure the lab book was up to date and printed off all the labs in the morning. The Nurse stated he glanced through the labs but did not notice the abnormal lab results for Resident #3. The Nurse stated he did not do anything with the labs except to fax them to the physician ' s office. The Nurse stated he divided the reports by halls and normally would give them to the nurse on the hall. The Nurse stated he did not remember exactly what he did with the labs on the morning of 1/29/15.

The Director of Nursing stated in an interview on 12/12/15 at 4:45 PM that the RP should be notified of a change in the resident ' s condition.

The RP stated in an interview on 2/19/15 at 9:50 AM he did not receive notification of abnormal lab work performed while the resident was in the facility. The RP stated various family members visited the resident in the facility and while on the C-Wing there was very little communication with the family regarding the resident ' s care.

1c. Resident #3 was originally admitted to the facility on 9/18/14 and had diagnoses that included Advanced Dementia, Generalized Weakness and Difficulty Walking.

A nurse ' s note dated 12/15/14 at 7:30 AM revealed a nursing assistant reported to the nurse that Resident #3 had skin opening on the right upper buttocks. The note revealed the area was assessed by the treatment nurse as shearing that measured 1.5 centimeters (CM) by 1.5 cm. The note revealed the 7AM to 3PM nurse was notified. A nurse ' s note dated 12/15/14 at 1:40 PM revealed the Responsible Party (RP) was notified

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the resident had skin breakdown on her bottom. There were physician orders dated 12/15/14 for treatment for the skin breakdown.

Treatment Nurse #1 stated in an interview on 2/11/15 at 11:10 AM the resident had an area on the right upper buttocks. The Nurse stated the resident was very confused, could be combative and refused care. The Treatment Nurse stated the resident frequently refused wound care but on 1/27/15 she went in to do a treatment and the resident agreed. The Treatment Nurse stated she saw the area on the right upper buttocks had become much larger to include the sacral area. The Treatment Nurse stated the physician was in the building and got him to come in to see the resident. The Treatment Nurse stated the physician measured the area on the right upper buttocks/sacral area at 6.1cm by 5.6cm by 1.1cm and staged at a stage III pressure ulcer. The Treatment Nurse stated the physician ordered a new treatment for the area.

Treatment Nurse #1 stated in an interview on 2/11/15 at 1:00 PM she did not notify the Responsible Party (RP) of the worsening of the pressure ulcer. There were no nurse ' s notes to show the RP had been notified of the worsening of the pressure ulcer or the new treatment.

The Director of Nursing stated in an interview on 12/12/15 at 4:45 PM that the RP should have been notified with a change in the resident ' s condition.

The RP stated in an interview on 2/19/15 at 9:50 AM he was not informed of significant pressure ulcers or worsening of pressure ulcers while the resident was in the facility. The RP stated various

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F 157	Continued From page 10 family members visited the resident in the facility and while on the C-Wing and there was very little communication with the family regarding the resident ' s care.	F 157		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff and family interviews the facility failed to provide treatment for a pressure ulcer as ordered by the physician for 1 of 3 sampled residents reviewed for pressure ulcers (Resident #3). The findings included: Resident #3 was originally admitted to the facility on 9/18/14 and had diagnoses that included Advanced Dementia, Generalized Weakness and Difficulty Walking. The Care Area Assessment (CAA) dated 9/25/14 for Cognitive Loss/Dementia revealed the resident had severe cognitive impairment with Behavior Disturbance. The CAA revealed the resident was able to communicate simple needs. The CAA for Activities of Daily Living (ADLs)	F 314	F314D 1. A. Resident #3's wound dressing should have ben changed the morning she went to the hospital, TX BID. B. Resident #3 will receive wound dressing changes as ordered by the physician. C. Residents with pressure ulcers have the potential to be affected. D. Residents with pressure ulcers will receive dressing changes as ordered by the physician. 2. A. A 100% audit has been completed to verify that the Treatment Administration Record (TAR) matches the physician's	3/20/15

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(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 314	Continued From page 11 revealed the resident did not like to get out of bed or perform any form of activity and required extensive assistance with ADLs. The CAA for Urinary Incontinence revealed the resident could alert staff when she needed to use the bathroom but stated she did not want to go to the bathroom and was going to use her incontinent brief creating risk for skin breakdown. The CAA for Pressure Ulcers revealed the resident had no skin breakdown on admission but was at risk due to slight immobility and urinary incontinence. The CAA revealed the resident could reposition herself with limited to extensive assistance depending on her cooperation. The CAA revealed the resident was continuously encouraged to get out of bed for at least an hour. The resident ' s Care Plan dated 11/25/14 revealed the resident refused care such as baths and grooming. The Care Plan instructed staff to explain all procedures to the resident and if resident refused, allow the resident time and come back later and try again. The Care Plan included an entry dated 11/28/14 that revealed the resident was verbally abusive with the staff and resisted ADL care. The Care Plan directed staff to provide a non-confrontational environment, anticipate care needs and reinforce positive behavior. The Care Plan directed staff to re-approach at a later time when agitated. The Care Plan revealed a potential for skin breakdown and to ensure resident was clean, dry and odor free and assist resident with repositioning in bed every 2 hours. The Care Plan directed staff to assess skin daily with AM care and as needed. An entry dated 12/15/14 revealed the resident had shearing to the right upper-mid buttocks and to provide treatment as ordered. The Care Plan directed staff to notify the	F 314	orders. 3. A. The Director of Nursing (RN) in-serviced the Wound Care Nurses (RN/LPN) concerning transcription of new treatments orders, reconciliation of treatment orders during the monthly turnover and providing treatments per the physicians order. B. Any Wound Care Nurse (RN/LPN) who is non-compliant with transcription of new treatment orders, reconciliation of treatment orders during the monthly turnover and providing treatments per the physicians order will receive counseling and re-education as indicated. 4. A. A monitoring form has been developed for transcription of new treatment orders and providing treatments per the physician's order. The monitoring will be completed by the Interdisciplinary Team Member(s).. The monitoring will occur as follows: At least 3 patients per unit (total of 9 patients) with new treatment orders will be verified against the treatment administration record for accuracy of transcription for a duration of: 4 times per week for 4 weeks 3 times per week for 4 weeks 2 times per week for 4 week 1 time per week for 4 weeks Then monthly for 3 months or until major compliance by the Quality Assurance Committee.	

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F 314	Continued From page 12 physician if no improvement in 2 weeks and to monitor area for increased breakdown and signs of symptoms of infection and to notify the physician if present. A nurse ' s note dated 12/15/14 revealed a nursing assistant reported to the nurse the resident had skin opening on the upper buttocks. The note revealed the treatment nurse measured the area at 1.5 centimeters (cm) by 1.5 cm and described as skin shearing to the upper buttocks. There was a physician ' s order dated 12/15/14 to clean the open area to the right upper buttocks with normal saline and apply a xeroform dressing and cover with dry gauze, secure and change every 3 days and as needed. A Quarterly Minimum Data Set (MDS) Assessment dated 12/18/14 revealed there were verbal behavioral symptoms directed toward others and rejection of care daily. The MDS revealed the resident required extensive assistance with bed mobility, total assistance with toileting and extensive assistance with personal hygiene. The MDS revealed there was no impairment of the upper or lower extremities. The MDS revealed the resident was at risk for pressure ulcers (PU), had no unhealed PU and had moisture associated skin damage. The MDS revealed a pressure reducing device for the bed and nonsurgical dressings and the application of ointment/medications. A wound note dated 12/29/14 revealed the resident was placed on an air mattress Review of the nurse ' s notes for resident #3 from 12/1/14 through the end of January revealed	F 314	The Skin Integrity Coordinator or Interdisciplinary Team Member(s) will observe at least 3 patients per unit (total of 9 patients) to ensure the dressing has been changed and that the treatment administration record has supporting documentation for a duration of: 4 times per week for 4 weeks 3 times per week for 4 weeks 2 times per week for 4 week 1 time per week for 4 weeks Then monthly for 3 months or until major compliance by the Quality Assurance Committee. B. The Interdisciplinary Team member (Unit Managers, RN, Clinical Competency Coordinator, RN, Wound Care Nurse, Quality Assurance Coordinator, RN, Director of Nursing, RN, and/or Administrator)will review the reconciliation of treatment orders during the monthly turnover monthly times 3 months. Results of monitoring with tracking and trending will be reported by the Quality Assurance Coordinator (RN) monthly to the Quality Assurance Committee for recommendations and suggestions for improvements or changes.	

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almost daily refusal of care, medications, refusing to allow incontinent care and was verbally abusive to staff.

Treatment Nurse #1 stated in an interview on 2/11/15 at 11:10 AM the resident was confused and combative from the middle to the end of January 2015 and frequently refused wound care. The Treatment Nurse stated on 1/27/15 she went in to do the treatment and the resident agreed. The Treatment Nurse stated she started the treatment and realized the area had become much larger to include the sacral area. The Nurse stated the physician was in the building and got him to see the resident. The Nurse stated the physician measured the wound at 6.1cm by 5.6cm by 1.1cm with no tunneling and light exudate. The Treatment Nurse stated the physician ordered a different treatment for the wound.

A physician ' s progress note dated 1/27/15 revealed the resident had a Stage IV non-infected sacral ulcer that measured 6.1cm by 5.6cm (there was no depth listed in the notes).

There was a physician ' s order dated 1/27/15 to clean the sacral area with normal saline, apply an antibiotic ointment to the area twice a day and cover with gauze and secure.

Review of the Treatment Administration Record (TAR) revealed the resident refused wound treatments on January 14, 2015 through January 23, 2017. According to the TAR the resident allowed the treatment to be done on January 24, 2015 and refused wound care on January 25-26, 2015. The TAR revealed the new order on the January TAR beginning on 1/27/15 that was to be

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done twice a day. The treatment was initialed as done by Treatment Nurse #1 on January 27, 28, 29 and a different nurse on the 31st. There were no initials to show the treatment was done at all on the 30th and no initials to show the treatment was done a second time on January 27, 28, 29 or 31. Review of the February 2015 TAR revealed the order dated 12/15/14 for the Xeroform dressing to be done every 3 days and as needed. The February 2015 TAR did not contain the new physician ' s order dated 1/27/15 for the antibiotic dressing to be done twice a day. The February TAR contained the initials of Treatment Nurse #1 for one treatment and the symbol for changed on February 1, 2015. A wound assessment sheet dated 2/1/15 revealed the area on the right upper buttocks had no signs of infection and revealed measurements that revealed an increase in the depth of the pressure ulcer. The measurements were 6.1cm by 5.6cm by 2.5cm. On February 2, 2015 there was a checkmark and the initials of Treatment Nurse #2. Treatment Nurse #2 stated in an interview on 2/12/15 at 9:05 AM the checkmark on the February 2015 TAR for 2/2/15 meant the resident ' s sacral dressing was dry and intact. The Nurse stated the order was to change the dressing every 3 days and she did not change the dressing on 2/2/15. The Nurse stated there was not an order on the February 2015 TAR for a treatment to be done twice a day. On February 3, 2015 " HOSP " (hospital) was written under the date. There was a physician ' s order dated 2/3/15 at 1:00 PM to discharge the resident to the hospital. There were no initials to indicate a treatment had been done on February 3, 2015 prior to being discharged to the hospital. There was no information on the TAR and no nurse ' s notes that the resident refused the treatments.

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The Unit Coordinator on the C-Wing stated in an interview on 2/11/15 at 1:20 PM Treatment Nurse #2 was assigned to check the January 2015 TAR with the February 2015 TAR and the physician ' s orders to ensure the February TAR was accurate.

Treatment Nurse #2 stated in an interview on 2/11/15 at 1:25 PM she started checking the TARs about one week prior to the end of the month and pointed where she had put a check mark and initials by the order on the TAR that the order was correct. The Nurse stated she checked the TAR prior to 1/27/15 when the new order was written. The Nurse stated on February 1, 2015 the Treatment Nurse that put the new TARs in the treatment book was supposed to check to ensure there were no additional orders and the new TAR was accurate.

The Director of Nursing (DON) stated in an interview on 2/11/15 at 3:40 PM the staff started checking the TARs 4-5 days prior to the end of the month and were supposed to check the new TAR with the TAR from the previous month as well as the actual physician ' s orders. The DON stated after that when a new order was received, the nurse was supposed to write the new order on the upcoming month ' s TAR. The DON stated the nurses had been trained to do this.

Treatment Nurse #1 stated in an interview on 2/12/15 at 3:19 PM that February 1, 2015 was a Sunday and she was the only treatment nurse in the building. The Nurse stated the February 2015 TAR was already in the treatment book and she was rushing and removed the January TAR and continued with the order on the February TAR which was the old order and did not compare the

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F 314	Continued From page 16 two TARs. The Nurse stated this was her mistake. Review of hospital records revealed wound cultures of the sacrum and right hip wounds were obtained on 2/3/15 while in the Emergency Department (ED). The hospital admission History and Physical dated 2/3/15 under Physical Examination, Extremities read: " There is a sacral decubitus ulcer stage 4 and right hip decubitus with foul smelling discharge noted. " The results of the wound cultures obtained in the ED were reported on 2/5/15. The results revealed moderate to heavy growth of normal skin flora. An operative note dated 2/6/15 revealed debridement of the sacral ulcer including skin, subcutaneous tissues, muscle and fascia measuring 11cm by 11cm by 3cm and debridement of a right hip decubitus measuring 4cm by 3cm by 2cm and the placement of a wound vac (vacuum). The Responsible Party (RP) stated in an interview on 2/9/15 at 7:55 PM the resident did not seem to be in much pain prior to the debridement of the pressure ulcers on 2/6/15. The RP stated after the debridement of the pressure ulcers the resident had significant pain that required a Fentanyl drip intravenously. Fentanyl is a medication used to treat severe pain.	F 314		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels,	F 325		3/20/15

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F 325	Continued From page 17 unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to notify the physician of all dietary recommendations and failed to implement the dietary recommendations for 1 of 3 sampled residents (Resident #3). The findings included: Resident #3 was admitted to the facility on 9/18/14 and had diagnoses that included Advanced Dementia, Generalized Weakness and Difficulty in Walking. The Care Area Assessment (CAA) for Cognitive Loss/Dementia dated 9/25/14 revealed the resident had severe cognitive impairment with behavior disturbance. The CAA revealed the resident could communicate verbally and was able to communicate simple needs. The CAA for Nutrition revealed the resident preferred to eat in her room. The CAA revealed the resident was on a No Added Salt diet and her meal intake was from 25-100% of meals. The CAA revealed the resident was able to feed herself after tray set-up. The resident ' s Care Plan dated 9/25/14 revealed the resident required staff assistance for activities of daily living (ADLs). The Care Plan revealed the resident had the potential for skin breakdown due to incontinence. Among the interventions were as follows: Report decline in	F 325	F325D 1. A. For Resident #3: The corrective action was not done as the resident is currently in the hospital. B. Residents with Dietary Recommendations will have their physician notified and implemented as ordered. 2. A. The Registered Dietician and Dietary Manager conducted a 100% audit on 3/5/15 of dietary recommendations on made since 12/17/2014. 3. A. A new process for notification of physician concerning dietary recommendations has been implemented. Nursing will no longer call the physician's office nurse concerning dietary recommendations. When there is a dietary recommendation the physician/physician extender will be notified for additional orders if indicated. B. The Registered Dietician and Dietary Manager will be in-serviced at this time and upon hire on ensuring physician was	

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F 325	Continued From page 18 intake to physician, Offer beverages and Dietician to evaluate patient ' s nutritional status. The Care Plan revealed a potential for alteration in nutrition and included the following approaches: Weight per protocol. Diet as ordered. Dietary supplements as ordered. The Care Plan was updated as follows: 11/25/14 Resident rejects care such as refusing baths and grooming. 11/28/14 Resident verbally abusive with staff and resists ADL care. A nurse ' s note dated 12/15/14 revealed a nursing assistant reported to the nurse the resident had skin opening on the upper right buttocks. The note revealed the area was assessed by the treatment nurse and measured 1.5centimeters (cm) by 1.5cm skin shearing to upper buttocks. Review of the physician ' s orders revealed orders dated 12/15/14 for treatment of the area. The Care Plan was updated as follows: 12/15/14 Resident has current skin concerns: R upper-mid buttocks (shearing). Encourage to allow staff to perform ADLs/Treatments. Pt non-compliant with care (abusive verbally/physically). A Dietary Assessment dated 12/17/14 revealed the resident was on a No Added Salt diet with regular texture and refused to be weighed. The note revealed the resident stayed in bed most of the time, had poor intake of food and fluids and refused medications and care. The note revealed the resident was not consistently meeting her nutritional needs and a multi-vitamin (MVI) was in place. The note revealed an appetite stimulant was recommended and the recommendation was given to a nurse. The Dietary Manager (DM)	F 325	notified of dietary recommendations and implementation of dietary recommendations. C. Nurses will be in-serviced at this time and upon hire on dietary recommendations received on a phyician's order form to ensure the physician/physician extender was notified of dietary recommendations and implementation of dietary recommendations. D. Those employees not in compliance with notification of physician concerning dietary recommendations and implementation will be counseled and receive re-education as indicated. 4. A. Quality Assurance Checklist has been completed/implemented by the Registered Dietician and Dietary Manager for dietary recommendations to ensure the physician/physician extender was notified and recommendations were implemented. The monitoring will occur: 4 times per week for 4 weeks 3 times per week for 4 weeks 2 times per week for 4 weeks Then monthly for 3 months B. The Administrator/Director of Nursing will monitor for compliance with dietary recommendations to ensure the physician/physician extender was notified and recommendations were implemented. The monitoring will occur monthly times 3 months. C. Results of monitoring with tracking and trending will be reported by the Registered Dietician monthly to the Quality Assurance	

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F 325	Continued From page 19 stated in an interview on 2/12/15 at 9:10 AM he did not remember what nurse he gave the dietary recommendations to on 12/17/15. The DM stated the recommendations were usually carried out that day or the next day. The DM was not aware the recommendations had not been initiated. Review of a Medical Nutritional Therapy Recommendations Form dated 12/17/14 revealed the following recommendations from the dietary manager for Resident #3: " 1. Appetite stimulant. PO (by mouth) intake 22% average per day. Poor fluid intake. 2. Standard 2.0 90 milliliters (mls) three times per day. Record percent of intake. Standard 2.0 is a high protein, nutritional supplement. " Review of the physician ' s orders revealed no orders for an appetite stimulant or supplements in December 2014. Review of the Medication Administration Record for Resident #3 for December 2014 revealed no entries for an appetite stimulant or supplements other than the MVI. The Resident ' s Care Plan was updated as follows: 12/17/14 Refusing to be weighed. Very poor intake of food and fluids. Recommend appetite stimulant. Encouraged to be weighed and supplements as ordered. A Quarterly Minimum Data Set (MDS) Assessment dated 12/18/14 revealed the resident had severe cognitive impairment and verbal behavioral symptoms toward others and rejection of care that occurred daily. The MDS revealed the resident required extensive assistance with bed mobility, was non-ambulatory and required total assistance with toileting and extensive assistance with personal hygiene. The MDS revealed the resident was incontinent of bowel and bladder	F 325	Committee for recommendations and suggestions for improvements or changes.	

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and was on a therapeutic diet. The MDS revealed the resident was at risk for pressure ulcers but had no unhealed pressure ulcers. The MDS revealed the resident had moisture associated skin damage and had a pressure reducing device for the bed and nonsurgical dressings and the application of ointment/medications.

On 2/10/15 at 12:33 PM, the Dietary Manager (DM) stated in an interview the resident was quite demented and never had a great appetite since admission. The DM stated the biggest concern was her fluid intake. The DM stated the resident would have 2 or 3 half empty drinks on her table but would not finish anything. The DM stated he tried to encourage her to drink and her family members tried to get her to drink but were unsuccessful. The DM stated he would take the resident ice cream he knew she liked and she would eat several bites and would not eat anymore. The DM stated the resident had been refusing to be weighed since October 2014.

In an interview with Nurse #3 on 2/12/15 at 4:05 PM, the Nurse stated she put the time at the top of the Nutritional Therapy Recommendations Form that she faxed and called the nurse at the physician ' s office with the dietary recommendations for Resident #3. The time 2:10 PM and the physician ' s nurse ' s name was at the top right hand corner of the form. The Nurse stated she worked on different halls within the facility and was not on the same hall the next day and did not follow-up on the dietary recommendations.

On 2/12/15 at 4:30 PM the Nurse in the physician ' s office stated in an interview she received a phone call from Nurse #3 on 12/17/15 for an

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F 325	Continued From page 21 order for Standard 2.0 90 mls three times a day. The Nurse stated she did not receive a request for an appetite stimulant. The Nurse stated she called the facility with an order for the Standard 2.0 90 mls three times a day on 12/17/15 at 5:00 PM. The physician ' s Nurse stated she did not know who she gave the order to at the facility. The Director of Nursing (DON) stated in an interview on 2/12/15 at 4:45 PM she had the physician ' s nurse fax her a copy of the dietary recommendation received at the physician ' s office on 12/17/15. The copy of the dietary recommendation form read: " 1. Appetite stimulant. PO (by mouth) intake 22% average per day. Poor fluid intake. 2. Standard 2.0 90 milliliters (mls) three times per day. " Record percent of intake. The DON stated they definitely had a communication problem.	F 325		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to notify the physician of abnormal lab results that revealed dehydration for 1 of 3 sampled residents reviewed for dehydration (Resident #3). Resident #3 was admitted to the hospital on 2/3/15 with diagnoses that included Severe Dehydration and Acute Renal Failure. The findings included:	F 327	F327D 1. A. For Resident #3: The corrective action was not done as the resident was in the hospital. B. Resident's physician/physician extender will be notified of critical/abnormal labs. C. A 100% audit was completed on labs	3/20/15

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F 327	Continued From page 22 Resident #3 was originally admitted to the facility on 9/18/14 and had diagnoses that included Advanced Dementia and Generalized Weakness. The Care Area Assessment (CAA) for Cognitive Loss/Dementia dated 9/25/14 revealed the resident had cognitive deficits with a diagnosis of Dementia with Behavioral Disturbance. The CAA revealed the resident did communicate verbally and was able to communicate simple needs. The CAA for Nutrition dated 9/25/14 revealed the resident was able to feed herself after tray set-up. Record review revealed laboratory test results dated 11/15/14 that revealed the resident ' s Blood Urea Nitrogen (BUN) was 16 (Normal range 6-23) and Creatinine was 0.89 (Normal range 0.50-1.10). A BUN and Creatinine reflect how well the kidneys are working. The resident ' s Care Plan dated 12/17/14 revealed a potential for altered nutrition due to the resident ' s very poor intake of food and fluids. The Care Plan was for staff to encourage intake of food and fluids. A Dietary assessment dated 12/17/14 revealed the resident had poor intake of food and fluids and refused medications and personal care. A Quarterly Minimum Data Set (MDS) Assessment dated 12/18/14 revealed the resident had severe cognitive impairment but was independent with eating after tray set-up. A Nursing Monthly Assessment Form dated 1/5/15 revealed the resident had a poor appetite. Review of physician ' s progress notes dated	F 327	drawn on 1/27/15 to verify all abnormal lab results were reported to the physician/physician extender. D. A 100% audit will be completed on labs drawn from 1/28/15 to 2/9/15 to verify all abnormal labs were reported to the physician/physician extender. 2. A. New process for notification of physician/physician extender concerning abnormal/critical labs: Nursing will no longer call the physician's office nurse concerning abnormal/critical labs. When there is a critical lab the physician/physician extender will be notified on the day the lab results received for additional orders if indicated. When there is an abnormal lab the physician/physician extender will be notified by the next day for additional orders if indicated. The Nurse who notified the physician of the critical/abnormal labs will document on the lab the physician's response. The labs with the documented responses will then be faxed to the physician/physician extender for further review. B. All nurses will be in-serviced and new nursing employees will be in-serviced prior to providing direct resident care concerning reporting critical/abnormal labs to the physician/physician extender. C. Nurses who are non-compliant with reporting critical/abnormal labs to the physician will be counseled by nursing	

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F 327	Continued From page 23 1/27/15 revealed the physician evaluated the resident with documentation of wounds including a sacral pressure ulcer that had worsened with an increase in size. A radiology report revealed a chest x-ray was done on 1/28/15. The report revealed a possible right lung base infiltrate (possible pneumonia). At the bottom of the report was a hand written note that read: " Faxed & called in 1/29/15 and followed by the initials of the person who faxed and called in the report. A nurse ' s note dated 1/29/15 read: " New orders received via telephone r/t (related to) CXR (chest x-ray) results. There was a hand written physician ' s telephone order (TO) dated 1/29/15 for an antibiotic by mouth daily for 7 days with the following signature: " T.O. Name of physician/name of physician ' s nurse/name of nurse at facility that took the order. " A laboratory (lab) results sheet revealed blood for a Complete Blood Count and Comprehensive Metabolic Panel (CMP) was collected on 1/28/15 at 6:00 AM. The results included a white blood cell count (WBC) of 19.5H (H meaning high). The normal range was listed as 4.0-10.5. A high WBC would indicate infection. The BUN was 85H (normal range 6-23). The Creatinine was 1.66H (normal range 0.50-1.10). An elevated BUN and Creatinine could indicate dehydration. The lab sheet revealed the labs were printed at the facility on 1/29/15 at 5:18 AM. There was information stamped on the sheet that read: " FAXED JAN 29 2015. " There was not a time or initials of the person who faxed the information. There was no documentation in the nurse ' s notes of the lab results or that the physician was notified of the results. There were no additional physician ' s	F 327	administration and receive additional education when indicated. 3. A. A monitoring form has been developed for the notification of the physician concerning abnormal labs.The monitoring will be completed by the Interdisciplinary Team Member(s). The monitoring will occur as follows: At least 3 patients per unit (total of 9 patients) with critical labs/abnormal labs will be monitored along with notification of physician/physician extender of critical labs/abnormal labs for a duration of: 4 times per week for 4 weeks 3 times per week for 4 weeks 2 times per week for 4 week 1 time per week for 4 weeks Then monthly for 3 months 4. Results of monitoring with tracking and trending will be reported by the Quality Assurance Coordinator (RN) monthly to the Quality Assurance Committee for recommendations and suggestions for improvements or changes.	

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orders related to the test results after the antibiotic order dated 1/29/15 until 2/3/15 when there was an order to send the resident to the hospital. There were no additional physician ' s progress notes until 2/3/15 when the physician gave an order to send the resident to the hospital.

The Dietary Manager (DM) stated in an interview on 2/10/15 at 12:33 PM that Resident #3 was quite demented and never had a great appetite since admission to the facility. The DM stated his greatest concern was her fluid intake; the resident would have 2 or 3 half empty drinks on the table but would not finish anything. The DM stated he encouraged her to drink and her family members would try to get her to drink but they were not successful. The DM stated he would take the resident ice cream that he knew the resident liked and the resident would take several bites and would not eat anymore.

The Physician caring for the resident in the facility stated in an interview on 2/10/15 at 3:55 PM that he must have seen the lab results because he gave an order for antibiotics for the high white count. The Physician stated he could not recall what his response to the elevated BUN and Creatinine was and would need to review the medical record.

In a separate interview on 2/11/15 at 2:08 PM the Physician stated he could not find any physician documentation regarding the resident ' s elevated BUN and Creatinine. The Physician stated he felt like it was addressed because he had put the resident on an antibiotic for the high white count. The Physician stated for the resident ' s elevated BUN and Creatinine he normally would have told the staff to increase fluids by mouth or start

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intravenous (IV) fluids and if that did not work would send the resident to the hospital. When asked if he was aware the resident was not drinking very well the Physician stated he was aware the resident refused care and medications. The physician was asked the question a second time but did not answer the question.

On 2/11/15 at 2:55 PM an interview was conducted with the physician ' s office nurse. The Nurse stated her job was to answer phone calls, receive faxed information and relay messages to the physician. The Nurse stated she had documentation for all the calls she received and the physician ' s response to the calls. The Nurse stated she received a call from the facility on the morning of 1/29/15 regarding an abnormal chest x-ray. The Nurse stated she read the results of the x-ray to the physician and at 4PM on 1/29/15 she called the facility with an order for an antibiotic. The Nurse stated she did not receive any phone calls from the facility on 1/29/15 or 1/30/15 with regards to abnormal lab work. The Nurse stated the facility was supposed to fax and call the office with any abnormal lab results.

An interview was conducted with the Director of Nursing (DON) and the C Wing Unit Coordinator on 2/11/15 at 3:40 PM. The DON stated critical lab results were to be called to the physician ' s office during office hours and directly to the physician when outside office hours. The DON stated the lab results should have been called to the physician.

Nurse #1 stated in an interview on 2/11/15 at 4:05 PM that she worked on the 7AM-3PM shift on 1/29/15. The Nurse stated she faxed the chest x-ray report and called the office regarding the

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abnormal report. The Nurse was observed to review the lab results printed at the facility on 1/29/15. The Nurse stated she never saw the lab work and would have definitely called the physician ' s office with the high BUN and Creatinine had she seen the lab results.

Nurse #2 stated in an interview on 2/12/15 at 8:14 AM that he mostly worked with the QI (Quality Improvement) Nurse, made sure the lab book was up to date and printed off all the labs in the morning. The Nurse stated he stamped all the labs with a faxed stamp that included the date. The Nurse stated he could go to the computer and print all unprinted labs at one time. The Nurse stated on the morning of 1/29/15 he printed off 31 lab results and put them all in the fax machine at one time and faxed them to the physician ' s office. The Nurse stated he usually put all the lab results for each hall together and would give to the nurse on the hall. The Nurse stated he did not do anything with the labs except fax them to the physician ' s office. The Nurse stated he did not remember what he did with the labs on the morning of 1/29/15. The Nurse stated he was aware the nurses were to call critical lab results to the physician but the nurse on the hall did this. The Nurse could not explain what happened to the labs or who he gave them to on the morning of 1/29/15.

The DON stated in an interview on 2/12/15 at 2:30 PM she spoke with the nurse at the physician ' s office and asked her to fax to the facility any labs she had in the system for Resident #3. The DON stated the labs she received revealed the labs were faxed to the physician ' s office on 1/29/15 at 7:42 AM. The DON stated the staff should have made a phone

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F 327	Continued From page 27 call to the physician ' s office regarding the abnormal lab results. The DON stated in an interview on 12/12/15 at 4:45 PM the physician wanted abnormal lab results to be faxed to the nurse in his office followed-up by a phone call and the nurse relayed the lab results to the physician who would give the nurse orders, if any and the nurse called the order to the facility. Review of the nurse ' s notes revealed on 2/3/15 Resident #3 became unresponsive in the dining room and was returned to her room where the physician saw the resident and gave an order for the resident to be discharged to the hospital. Review of the hospital Admission History and Physical dated 2/3/15 revealed the following: " In the ER (Emergency Room) blood pressure of 60s/50, heart rate 100 and temperature 95.6. Breathing and oxygen saturation were normal but was found to be very dehydrated. The family still wants full code for this patient so patient will go to the ICU (intensive care unit) for further management. Physical Examination: General: Patient is now awake, following simple commands but not oriented and looks very dehydrated. Laboratory Data: WBC (serum white blood cell count) 27,000, sodium 146, potassium 5.3, chloride 111, BUN 101, creatinine 3.6. Urinalysis: 1+ blood, trace of ketones, 3+ leukocyte esterase, WBC more than 180, RBC 120, 3+ bacteria. Chest x-ray unremarkable. Assessment: 1. Altered Mental Status and is lethargic possibly secondary to severe septic shock with hypotension, lactic acidosis and leukocytosis. 2. Possibly the source of infection is urinary tract. 3.	F 327		

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F 327	Continued From page 28 Acute renal failure, possibly from septic shock, dehydration and lack of oral intake. 4. Source of infection possibly the sacral ulcer as well as right hip decubitus ulcer. Will give IV fluids. Patient responded to the IV fluids that were given in the ER. "	F 327		