STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345354	A. BUILDING _____ B. WING _____	C 04/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY GROVE NURSING AND REHABILITATION CENTER	**728 PINEY GROVE ROAD KERNERSVILLE, NC 27284**

(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 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 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. This REQUIREMENT is not met as evidenced by: Based upon record review and staff interview, the facility failed to update the care plan for 1 of 3 sampled residents (Resident #1). The findings included: Resident #1 was admitted to the facility on 9/5/2013 and readmitted on 1/27/2015 from the hospital. Her cumulative diagnoses included cognitive communication deficit, fracture of vertebrae, dementia with behaviors and anxiety. Resident #1 was discharged from the facility on 2/27/2015. A review of Resident #1 ' s most recent Minimum Data Set (MDS) dated 2/24/2015 revealed that	F 280	F 280 Participate in Care Planning Resident #1 was discharged from the facility to the hospital on 2/28/15 and did not return to the facility. DON/SDC immediately started an in-service addressing updated care plans. This in-service was completed on 4/20/15 for 100% of MDS nurses involved in care plans. 4/27/15 The facility has a system in place to ensure that the care plans are updated.	4/27/15

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

Electronically Signed | 04/23/2015

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F 280	Continued From page 1 the resident had moderately impaired cognition skills and required extensive assistance for most activities of daily living (ADLs). A review of Resident #1 ' s medical record revealed that the most recent Care Plan was dated 10/19/2013. There was no evidence of the Care Plan having been updated. On 3/20/2015 at 12:00 PM, an interview was conducted with the DON (Director of Nursing), who stated that they do not have an updated Care Plan for Resident #1. The MDS nurse was no longer employed by the facility at the time of the investigation.	F 280	On 4/15/15, 100% audit of resident care plans was initiated by the DON, MDS and QI nurse to ensure care plans were updated. These updates will be completed on 4/27/15 by the MDS nurses. Care plans will be monitored for updates by utilizing a Care Plan Audit tool. The DON, QI nurse, and SF will utilized the Care Plan Audit tool 5x weekly for four weeks then bi-weekly for 4 weeks and then monthly for 3 months. 4/27/15 The DON/QI/SDC will present all findings of the QI monitoring tool at the monthly QI meetings x3 months. 4/27/15 The Administrator will utilize a QI monitoring tool (Administrator Auditing Tool) to ensure the Care Plan Audit tool is being completed. The auditing will be completed biweekly x4 weeks, then weekly x4 weeks, then monthly for 3 months. The Administrator will present findings at the next quarterly Executive Committee meeting for further recommendations. 4/27/15	
F 333 SS=D	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 medical record review and staff interviews, the facility failed to give Coumadin as	F 333	F 333 Medication Errors Resident Medical Record # 1 was	4/27/15

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F 333	Continued From page 2 ordered upon discharge by the hospital for 1 for 3 residents reviewed for medication errors (Resident #1). Finding included: Resident #1 was admitted to the facility on 1/27/15 with a pertinent diagnosis that included deep vein thrombosis (DVT) for which she was started on Coumadin 5 mg at the hospital. During the hospital admission, Resident #1 developed high International Normalized Ratio (INR) laboratory value which resulted in the hospital holding the Coumadin and suggesting that the INR be rechecked the following morning and Coumadin restarted at a lower dose. The hospital discharge summary dated 1/27/15 stated "Acute left lower extremity DVT - was initially started on Lovenox and Coumadin. INR was 4 on day prior to discharge and trended down to 3.2 on day of discharge. Recommend holding Coumadin tonight. Repeating INR tomorrow and then resuming at 3 mg daily starting on Wednesday 1/28/15 if INR appropriate. Goal INR 2-3." Of note, the Coumadin was not listed on the hospital discharge medication list. The omission error was not discovered at the nursing facility until 2/7/15, when the family inquired from Nurse #1 about the dose of Coumadin. The nurse's note dated 2/7/15 at 11:58 PM stated "family member in to visit this PM. Questions dose of Coumadin taking. Director of Nursing (DON) notified, physician notified, orders received and implemented, daughter notified." Nurse #1 was interviewed at 2:15 PM on 3/20/15. She stated "The resident's daughter asked me about the Coumadin dose and I just couldn't	F 333	admitted into the hospital for Deep Vein Thrombosis on 1-20-2015. She returned to the facility on 1/27/2015. The resident came back with a Coumadin order. The Coumadin order was in the body of the discharge summary and not listed on the discharge medication reconciliation list. The Coumadin order was discovered 2/7/15 after the resident□s daughter asked Nurse #1 about the Coumadin dose. After notifying the Director of Nursing (DON), the physician was notified on 2/7/14. An order was received to draw blood and test for Coumadin levels. An International Normalization Ratio (INR) was drawn on 2/7/15 by the Laboratory Company. The physician was notified of the INR results on 2/8/15 by charge nurse. The resident received 5mg of Coumadin stat on 2/7/15. She received 5mg on the 2/8/15. She received 7.5mg of Coumadin on 2/9/15. Then she received a scheduled dose of 5mg the following days. The resident□s next INR was drawn on 2/15/15. The resident□s daughter was notified of the physician□s orders by charge nurse on 2/8/15. 4/27/15 100% of all new admission/readmission medications will be reviewed by the DON, QI nurse or the Staff Facilitator (SF). This information will be compared to the discharge summary. Any discrepancies will be clarified immediately with the resident□s primary care provider. A QI monitoring tool, Review of Admission/Readmission Medications, will be utilized for all	

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F 333	Continued From page 3 believe that she wasn't on Coumadin or hadn't had any for 11 days since at the facility. I called the DON who...told me to call the physician. The physician gave orders to check INR and start Coumadin and we went from there. I just was so shocked that we missed such an obvious thing for so long that I had a hard time explaining it to the family." Nurse #2 was the nurse who reported the resident's readmission status to the physician and was interviewed on 3/20/15 at 2:30 PM. She stated "I am not aware of any Coumadin issue for Resident #1. I reported the admission diagnoses and medications to the physician but I don't recall specifically discussing DVT or Coumadin with the physician." The DON was interviewed on 3/20/15 at 2:30 PM. She stated "I don't remember anything unusual about (Resident #1's) Coumadin or speaking with Nurse #1 about it. In general, my expectations of proper reporting procedures, for when residents are re-admitted from the hospital, are for the admitting nurse to report all pertinent findings to the physician by phone. This includes diagnoses, laboratory values, medications, etc." The physician was interviewed on 3/20/15 at 3:30 PM. She stated that Resident #1 "was not anti-coagulated like she should have been. The nurse is supposed to look through the entire hospital discharge summary and report all significant things to me, but it gets to be so long and cumbersome to go through. I am not positive that the Coumadin information was reported to me. This was definitely an oversight; (Resident #1) should have been started on Coumadin ....There is no question about this miss."	F 333	admissions/readmissions. Monitoring utilizing the auditing tool will be completed with every admission/readmission five times weekly to include admissions/readmissions on nights and weekends x4 weeks, then bi- weekly x 4 weeks and monthly x 3 months by the DON, QI nurse or SF. 4/27/15 100% of licensed nurses will be in-serviced by the DON, QI nurse, SF on obtaining discharge medications from the discharge summary/medication reconciliation. The in servicing was initiated on 3/23/15. The education will include reading the body of the discharge summary in its entirety. Any orders not listed in the discharger orders/ medication reconciliation will be clarified immediately with the resident□s primary care provider. Date of completion for in-service is 3/26/2015. 4/27/15 The Administrator will in-service the DON, QI nurse, and SF on the Admission/Readmission Medication tool. This in-service was completed 3/31/15. 4/27/15 A 100% audit was completed by the DON on all residents receiving Coumadin on 3/8/15. The QI tool (Coumadin auditing tool) will be used to verify that all Coumadin orders are correct in each resident□s medical record. The Coumadin Audit tool will be completed by QI nurse or SF weekly on Friday. 4/27/15	

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F 333	Continued From page 4 The DON was interviewed again on 3/20/15 at 4:20 PM. She stated "Everyone has a role in this error - the hospital should have made sure Coumadin was on the discharge medication list because they know we look at that closely, nursing here at the facility should have looked at the entire discharge summary and paid particular attention to the word 'DVT'. We all dropped the ball and failed."	F 333	The Administrator will use a QI tool (Administrator Auditing tool) weekly to ensure the completion of the Review of Admission/Readmission medication tool bi-weekly x4, weekly x4 then monthly x3 months. 4/27/15 The DON, QI nurse, or SF will present findings from the QI tool (Review of Admission/Readmission Medication tool) at monthly QI meetings. The information from the monthly QI meetings will be presented by the administrator at the next Quarterly Executive QI committee meeting for any further recommendations. The Executive QI committee consists of Administrator, Director of Nursing, Quality Improvement Nurse, Dietary Manager, MDS Nurse, Social Worker and Medical Director. 4/27/15	