

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345354	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 9/15/2017
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NAME OF PROVIDER OR SUPPLIER PINEY GROVE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 728 PINEY GROVE ROAD KERNERSVILLE, NC
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 281	<p>483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>(b)(3) Comprehensive Care Plans</p> <p>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident and staff interviews, the facility failed to obtain a physician's order for hospice care for 1 of 1 sampled resident reviewed for hospice (Resident #108).</p> <p>Findings included:</p> <p>Resident #108 was admitted to the facility on 5/20/15 with diagnoses which included: chronic myeloproliferative disease (slow-growing blood cancer in the bone marrow), acute post hemorrhagic anemia, and diabetes mellitus.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated 6/20/17 indicated Resident #108 was cognitively intact requiring only supervision with setup assistance with activities of daily living (ADL) care.</p> <p>Resident #108 was readmitted to the facility after hospitalization (8/30/17-9/3/17) for recurrent gastrointestinal bleeding. The Re-admission Note dated 9/3/17 revealed the resident requested Comfort Care, Hospice.</p> <p>Review of the Physician's Telephone Order dated 9/4/17 documented: "Will follow resident, resident has less than 6 months to live."</p> <p>The review of the Social Worker's (SW) Note dated 9/5/17 revealed that on 9/4/17 the SW was notified by Hospice and Palliative Care of a hospice referral during Resident #108's hospitalization. The SW wrote that during a followed-up with the resident and her family, the resident stated "I don't want to keep going to hospital for blood. I want hospice but I want to stay here to do as much as I can until it's my time." The SW documented an order was written, verbalization was obtained from the Physician, and the facility's nursing staff were made aware.</p> <p>Review of the Hospice Plan of Care dated 9/6/17 revealed Resident #108 began hospice care on 9/5/17 due to the primary diagnosis of chronic myeloproliferative disease.</p> <p>A review of the facility's records revealed there was no Physician's Order documenting Resident #108 was to receive Hospice Care.</p> <p>During an observation and interview on 9/12/17 at 1:56 p.m., Resident #108 was awake and alert, sitting on</p>
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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

The above isolated deficiencies pose no actual harm to the residents

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F 281	<p>Continued From Page 1</p> <p>the side of her bed. The resident was noted with dark purple discolorations on bilateral arms. The resident revealed she had been frequently hospitalized for blood transfusions and had recently decided "no more", she had had enough. The resident indicated that although most of the time she was weak, she preferred to do as much of her ADL care herself as long as she was able.</p> <p>Resident #108's Care Plan was updated on 9/13/17 to include Palliative/Hospice Care due to disease process: gastrointestinal bleed. Interventions included: consult with hospice and the Physician regarding pain management.</p> <p>During an interview on 9/13/17 at 10:37 a.m., the Staff Development Coordinator (SDC) stated Resident #108 started hospice care on 9/5/17. The SDC indicated the order written on 9/4/17 "will follow resident, resident has less than 6 months to live" was not correct as written for hospice care. She stated the Physician's Telephone Order should have been written for hospice care.</p> <p>During an interview on 9/13/17 at 2:46 p.m., the Director of Nursing (DON) stated in her clinical opinion the physician's order dated 9/4/17 about Resident #108 having less than six months to live was too vague. The DON revealed her expectation was for the nurse to have written an order for the Physician to sign indicating "Hospice to evaluate and follow".</p> <p>On 9/14/17 at 8:44 a.m., Staff Nurse #2 (SN#2) stated that the SW informed her Resident #108 was to be under Hospice's care. SN#2 revealed the SW wrote the telephone order and she (SN#2) signed it. SN#2 stated she observed that the resident had less than six months of life left was written on the order; but did not recall if hospice care was included on the order.</p> <p>During an interview on 9/14/17 at 10:00 a.m., the SW acknowledged she wrote the physician's telephone order on 9/4/17 concerning Resident #108 after receiving a telephone call from Hospice on 9/4/17 requesting a hospice order for the resident. SW was informed by the Hospice representative that the resident and her family met with a Hospice representative while in the hospital and a verbal order was needed from the resident's Physician to receive hospice care. The SW stated that she wrote the telephone order as dictated by the Hospice representative and gave the telephone order to SN#2 to telephone the Physician then sign. The SW stated that she did not notice until it was brought to her attention on 9/14/17 that she failed to include that the resident was to receive hospice care on the physician's telephone order.</p>
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