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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 561 SS=G	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, physician interview, and staff interviews, the facility failed to honor the resident's decision and request to go to the hospital which resulted in delayed medical treatment for sepsis and spinal epidural abscess with nerve impingement in 1 out of 1 resident (Resident #1).	F 561	In addition to the Plan of Correction (POC) submitted, we also respectfully submit the following. Our center is registered with North Carolina QIO and we have reached out to them for additional assistance and support related to this survey cycle. The QIO has	12/4/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/04/2017

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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Findings included:

The resident was admitted on 9/5/17, discharged to the hospital 10/2/17 and readmitted to the facility on 10/27/17. The facility diagnoses were polysubstance abuse, osteomyelitis of vertebra thoracic, intra-spinal abscess, sepsis, thoracic discitis, and multiple back surgeries.

Resident #1's 14-day MDS dated 9/19/17 revealed the resident had an intact cognition, was not feeling depressed, and there was no psychosis or behavior. The resident was on scheduled and as needed pain medication regimen. The resident had frequent pain. Resident #1 had a care plan dated 9/5/17 that included goals and interventions for pain. The pain was to be assessed each shift and pain medication administered as scheduled and as needed.

Pain medication orders were: Gabapentin 300 milligrams 3 times a day ordered on 9/12/17 (anti-seizure medication used for nerve pain); Tizanidine 4 milligrams every 6 hours as needed for muscle spasm; Tylenol 1000 milligrams every 12 hours ordered on 9/27/17 (non-narcotic pain reliever); and Ibuprofen 800 milligrams 3 times a day ordered on 9/29/17 (anti-inflammatory).

Nurses' note dated 9/29/17 at 12:51 pm revealed Resident #1 had a pain assessment of 10 out of 10 almost constantly (level scale of 1 to 10 with 10 being the worst pain). The pain made it hard to sleep at night and caused limited day-to-day activities. The pain was documented as being new. The resident was not satisfied with his current level of pain.

F 561

scheduled a quality advisor to visit and assist in a broader QI plan for the center. It is our goal to utilize their expertise for process improvement related to compliance.

Resident #1 went to the hospital and received services on October 1st, 2017.

The Center Nurse Executive (CED) and Assistant Center Nurse Executive (ACNE) completed 100% audit of all residents for the desire for transfer to the hospital. No residents were determined to have the desire for transfer to the hospital. Any resident who is identified for transfer to the hospital or who had a significant change in condition, the physician will be notified at the time of discovery.

Licensed nurses, including weekend staff, agency and part time staff, were educated on 12/1/17 regarding honoring the residents' decision and request to be transferred to the hospital. The CNE, ACNE, Unit Managers (UM) will audit, through interviews, alert and oriented residents, five days per week including one weekend day x 4 weeks, two days per week including one weekend day x 4 weeks, then weekly x 4 weeks.

The CNE will review the findings of the audits and present findings to the Quality Assurance Performance Improvement (QAPI) team monthly for 3 months.

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Nurses' note dated 9/30/17 at 2:30 am Resident #1 was provided Tizanidine HCL 6 mg as needed for back pain (muscle relaxer).

Nurses' note dated 10/1/17 at 2:29 am Resident #1 was provided as needed Tizanidine HCL 6 mg for back pain.

Nurses' note dated 10/1/17 at 6:56 am Resident #1 was provided as needed Tizanidine HCL 6 mg for back pain.

Nurses' note dated 10/1/17 at 7:36 am Resident #1 complained he "can't stand the pain" and "requested to go to the hospital."

Nurse Practitioner (NP) progress note dated 10/1/17 revealed she received a voice mail from the facility at 7:26 am that Resident #1 requested to be sent to the hospital because of his back pain. The NP documented she returned the call at 9:13 am and ordered a urinalysis, urine culture and sensitivity, a back x-ray, and to be called when the results were available.

Nurses' note dated 10/1/17 at 5:01 pm revealed the family called to state Resident #1 was crying in pain on the phone and the facility was not doing anything about his pain. The family was informed there was an order for a back x-ray (which had not been done).

Nurses' note dated 10/1/17 at 5:18 pm revealed Resident #1's family arrived. The resident stated he was going to the hospital (signed himself out and left the building).

Nurses' note dated 10/1/17 at 5:23 pm revealed

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there were no orders to transfer to the hospital upon call back from the NP. The NP was notified at 5:24 pm that the resident signed himself out (to go to the ED) due to pain. The NP replied "ok."

NP progress note dated on 10/1/17 at 6:22 pm revealed the NP received a voice mail at 5:22 pm that Resident #1 was once again threatening to leave and go to the hospital due to his back pain. NP called the facility at 5:23 pm and was informed that the resident signed himself out and his family took him to the hospital. The note indicated the back x-ray and urinalysis had not been completed yet (in the facility).

A review of the 24-hour shift report for day shift dated 10/1/17 revealed the resident complained of lower back pain and as needed pain medications were given on night shift. At the end of night shift the resident stated he "can't stand the pain and wants to go to the hospital." The on-call Physician's Assistant was called and left a message. Staff was awaiting a call back.

A review of the Emergency Department's (ED) record dated 10/1/17 revealed Resident #1 was diagnosed with intractable back pain. The resident had blood cultures drawn. The resident was treated for pain with Dilaudid (strong narcotic pain reliever), Decadron (steroid to reduce acute inflammation) and Toradol (prescription anti-inflammatory) [pain medications not provided at the facility]. The neurosurgeon was consulted and a magnetic resonance image (MRI: scan of the body) of the lumber spine was ordered for the next morning.

A review of Resident #1's hospital record dated 10/2/17 revealed the resident had a magnetic

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resonance imaging (MRI: scans inside of the body) which reported a lumbar epidural abscess and sepsis (infection in the blood). The resident was admitted to the hospital and treated for sepsis resulting from the spinal abscess and required surgery to remove the spinal epidural abscess and to provide a laminectomy (orthopedic procedure to remove the vertebral disc and fuse two spinal processes together).

A review of the NP progress note dated 10/2/17 revealed the family took Resident #1 to the Emergency Department (ED) for intractable back pain 10/1/17. The resident received Dilaudid, Decadron, and Toradol, had blood cultures drawn, and an order for a magnetic resonance imaging (MRI) the next morning. The resident informed the NP that he was crying like a baby because the pain was so bad, he could not take it anymore.

On 11/28/17 at 2:00 pm an interview was conducted with Resident #1. Resident #1 stated that he had several days of uncontrolled pain. The resident informed the nurse, the NP and his family about the increased pain. The resident stated on 10/1/17 during the early morning the pain had gotten unbearable. The resident stated that he requested to go to the hospital several times because he knew something was wrong. The resident was informed the NP refused to send him to the hospital after waiting all day for an answer. The resident called his family crying in pain to take him. The resident stated that his family took him to the hospital on 10/1/17 in the evening.

On 11/28/17 at 4:00 pm an interview was attempted with the NP. The NP had resigned

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shortly after the 10/1/17 incident and was not available.

On 11/28/17 at 4:15 pm an interview was conducted with the Medical Director (MD). The MD stated that he was not familiar with Resident #1 and would need to review his medical record. The MD stated that Resident #1 could go to the ED if he wanted to. The NP made a judgement call to treat in the facility.

On 11/28/17 at 4:30 pm an interview was conducted with Nurse #1. Nurse #1 stated that she was assigned to Resident #1 on 9/28/17 the evening shift (3:00 pm to 11:30 pm). Nurse #1 stated that she was very familiar with the resident. Nurse #1 informed the NP at 11:59 pm that Resident #1 was having back pain 8 out of 10 scale that was not relieved with his regular scheduled medication. The NP ordered Ibuprofen 800 milligrams now one dose which was administered.

Nurse #1 stated that she was assigned to Resident #1 on 10/1/17 day shift (7am - 3:30 pm). The NP was called at 7:35 am and informed that the resident had increased acute back pain 10 out of 10 scale and this was a change. Nurse #1 stated that she received a call back from the NP toward the end of her day shift. The NP had ordered labs, back x-ray, and urinalysis and culture/sensitivity. Nurse #1 stated she informed the NP that the resident wanted to go to the hospital. According to Nurse #1, the NP replied, "I am not sending him to the hospital, he just wants more pain medication." Nurse #1 stated she informed the resident of the NP orders and the resident cursed and had become angry. Nurse #1 stated the resident informed her he

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"was not going to wait anymore" and was "going to call his family to take him" (to the ED). Nurse #1 stated that the resident had a right to go to the ED if he wanted. Nurse #1 stated that she had not waited almost an entire shift for a response from an NP in the past. Nurse #1 stated that she did not like to send a resident to the ED without an order. Nurse #1 stated that the Unit Manager was available 24 hours a day and she could have called her. Nurse #1 stated she would send a resident to the ED in an emergency via ambulance without an order if necessary. The next day during report Nurse #1 was informed that the resident's family came and took the resident to the ED.

On 11/28/17 at 5:28 pm an interview was conducted with the Medical Director (MD). The MD stated that he had reviewed Resident #1's record and remembered him. The resident had pain management issues secondary to polysubstance abuse. The MD stated the NP was called on 10/1/17 because of the resident's increased back pain. The NP ordered labs, urinalysis, and back x-ray and chose not to transfer to the ED. The MD felt this plan was reasonable. The MD stated that it was a resident's right to go to the ED and that if the facility staff felt the resident had a significant change they could send the resident without an order. The MD agreed that if the resident was to go to the ED himself there would be no medical information from the facility provided.

On 11/28/17 at 6:35 pm an interview was conducted with Nursing Assistant #1 (NA). The NA stated she was assigned to Resident #1 on 10/1/17 evening shift (3pm - 11:30 pm). The NA stated that the resident was "hurting real bad" and

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F 561	Continued From page 7 this was unusual for him. The NA stated that she was present when the resident's wife came to the facility and stated she was taking the resident to the ED. On 11/28/17 at 6:45 pm an interview was conducted with the Administrator. The Administrator stated that if a resident requested to go to the hospital it was his/her right to choose to go.	F 561		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 580		12/4/17

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F 580	Continued From page 8 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, physician interview, and staff interviews, the facility failed to notify the physician of the resident's significant change in condition which resulted in a delay of treatment for sepsis and a spinal epidural abscess with nerve impingement in 1 out of 1 resident (Resident #1). Findings included: The resident was admitted on 9/5/17, discharged to the hospital 10/2/17 and readmitted to the facility on 10/27/17. The facility diagnoses were polysubstance abuse, osteomyelitis of vertebra thoracic, intra-spinal abscess, sepsis, thoracic	F 580	In addition to the Plan of Correction (POC) submitted, we also respectfully submit the following. Our center is registered with North Carolina QIO and we have reached out to them for additional assistance and support related to this survey cycle. The QIO has scheduled a quality advisor to visit and assist in a broader QI plan for the center. It is our goal to utilize their expertise for process improvement related to compliance. Resident #1 went to the hospital and received services on October 1st, 2017.	

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discitis, and multiple back surgeries.

Resident #1's 14-day MDS dated 9/19/17 revealed the resident had an intact cognition, was not feeling depressed, and there was no psychosis or behavior. The resident was on scheduled and as needed pain medication regimen. The resident had frequent pain. Resident #1 had a care plan dated 9/5/17 that included goals and interventions for pain. The pain was to be assessed each shift and pain medication administered as scheduled and as needed.

A review of the 24-hour shift report dated 10/1/17 revealed the resident complained of lower back pain and as needed pain medications were given on night shift. At the end of night shift the resident stated he "can't stand the pain and wants to go to the hospital." The on-call Physician's Assistant (which is the Nurse Practitioner) was called and left a message. Staff was awaiting a call back.

Nurses' noted dated 10/1/17 at 7:25 am revealed Resident #1 was complaining of increased back pain and had requested to go to the hospital. The Nurse Practitioner was called and left a message about the pain and that the resident wanted to go to the hospital.

A review of the telephone/verbal order signature details dated 10/1/17 at 2:10 pm revealed the NP ordered an x-ray of the lower back and lumbar spine.

Nurses' note dated 10/1/17 at 5:23 pm revealed there were no orders to transfer to the hospital upon call back from the NP. The NP was notified

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The CNE and ACNE completed 100% audit of all residents for the desire for transfer to the hospital. No residents were determined to have the desire for transfer to the hospital. Any resident who is identified for transfer to the hospital or who had a significant change in condition, the physician will be notified at the time of discovery. If physician or any medical staff not in agreement to transfer the resident to the hospital, center staff will have resident transferred to hospital.

Licensed nurses, including weekend staff, agency and part time staff, were educated on 12/1/17 regarding alerting the physician concerning any significant change in condition as well as the residents' decision and request to be transferred to the hospital. The CNE, ACNE, UM will audit, through interviews, alert and oriented residents, five days per week including one weekend day x 4 weeks, two days per week including one weekend day x 4 weeks, then weekly x 4 weeks.

The CNE will review the findings of the audits and present findings to the QAPI team monthly for 3 months.

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at 5:24 pm that the resident signed himself out (to go to the ED) due to pain. The NP replied "ok."

Nurse Practitioner (NP) progress note dated on 10/1/17 at 6:22 pm revealed the NP received a voice mail at 5:22 pm that Resident #1 was once again threatening to leave and go to the hospital due to his back pain. NP called the facility at 5:23 pm and was informed that the resident signed himself out and his family took him to the hospital.

A review of the Emergency Department's (ED) record dated 10/1/17 revealed Resident #1 was seen and diagnosed with intractable back pain.

A review of the NP progress note dated 10/2/17 revealed the family took Resident #1 to the Emergency Department (ED) for intractable back pain 10/1/17.

On 11/28/17 at 2:00 pm an interview was conducted with Resident #1. Resident #1 stated that he had several days of uncontrolled pain. The resident stated on 10/1/17 during the early morning the pain had gotten unbearable. The resident stated that he requested to go to the hospital several times because he knew something was wrong. The resident was informed by Nurse #1 the NP refused to send him to the hospital after waiting all day for an answer. The resident called his family crying in pain to take him. The resident stated that his family took him to the hospital on 10/1/17 in the evening.

On 11/28/17 at 4:30 pm an interview was conducted with Nurse #1. Nurse #1 stated that she was assigned to Resident #1 on 10/1/17 day shift (7am - 3:30 pm). Nurse #1 stated that she

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F 580	Continued From page 11 was very familiar with the resident. The NP was called at 7:35 am and left a message that the resident had increased back pain and this was a change. Nurse #1 stated that she received a call back from the NP toward the end of her day shift. Nurse #1 stated that she had not waited almost an entire shift for a response from an NP in the past. Nurse #1 stated that she did not like to send a resident to the ED without an order. Neel #1 stated that the Unit Manager was available 24 hours a day for concerns and she could have called her for further instructions. Nurse #1 stated she would send a resident to the ED in an emergency via ambulance without an order if necessary. On 11/28/17 at 5:28 pm an interview was conducted with the Medical Director (MD). The MD stated that he had reviewed Resident #1's record and remembered him. The MD stated the NP was called on 10/1/17 because of the resident's increased back pain. The MD stated that it was a resident's right to go to the ED and that if the facility staff felt the resident had a significant change they could send the resident without an order. The MD agreed that if the resident was to go to the ED himself there would be no medical information from the facility provided. The MD stated that any clinician should call back as soon as possible when called by facility staff. The MD felt the facility staff should call the clinician back if there was no response in a reasonable amount of time or call other medical staff. The MD stated that five hours was not acceptable to respond to the facility.	F 580		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		12/4/17

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F 600	Continued From page 12 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, physician interview and staff interviews, the facility failed to initiate medical treatment for complaints of increased pain that was not managed by the current medication regimen in 1 out of 3 residents (Resident #1). Findings included: Resident #1 was admitted on 9/5/17, discharged to the hospital 10/2/17 and readmitted to the facility on 10/27/17. The facility diagnoses were poly substance abuse, osteomyelitis of vertebra thoracic, intra-spinal abscess, sepsis, thoracic discitis, and multiple back surgeries. Resident #1 ' s 14-day MDS dated 9/19/17 revealed the resident had an intact cognition, was not feeling depressed, and there was no psychosis or behavior. The resident was on scheduled and as needed pain medication regimen. The resident had frequent pain.	F 600	In addition to the Plan of Correction (POC) submitted, we also respectfully submit the following. Our center is registered with North Carolina QIO and we have reached out to them for additional assistance and support related to this survey cycle. The QIO has scheduled a quality advisor to visit and assist in a broader QI plan for the center. It is our goal to utilize their expertise for process improvement related to compliance. Resident #1 went to the hospital and received services on October 1st, 2017. Licensed nurses completed 100% pain assessment of all residents. No residents were determined to have unresolved or increased pain. If any resident verbalizes unresolved or increased pain, the physician will be notified at the time of	

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F 600

Continued From page 13

Resident #1 had a care plan dated 9/5/17 that included goals and interventions for pain. The pain was to be assessed each shift and pain medication administered as scheduled and as needed.

Nurses ' note dated 9/29/17 at 12:51 pm revealed Resident #1 had a pain assessment of 10 out of 10 almost constantly (level scale of 1 to 10 with 10 being the worst pain). The pain made it hard to sleep at night and caused limited day-to-day activities. The pain was documented as being new. The resident was not satisfied with his current level of pain.

Pain medication orders were: Gabapentin 300 milligrams 3 times a day ordered on 9/12/17 (anti-seizure medication used for nerve pain); Tizanidine 4 milligrams every 6 hours as needed for muscle spasm; Tylenol 1000 milligrams every 12 hours ordered on 9/27/17 (non-narcotic pain reliever); and Ibuprofen 800 milligrams 3 times a day ordered on 9/29/17 (anti-inflammatory).

A review of the medication administration record (MAR) for September and October 2017 revealed the resident was administered the Gabapentin, Tylenol and Ibuprofen as ordered. The pain assessment documented on the MAR was as follows:

9/28/18 at 9:00 am 0 level pain and 10:00 pm 8 level pain;
9/29/17 at 9 am 5 level pain and 10:00 pm 8 level pain;
9/30/17 at 9:00 am 10 level pain and 10:00 pm 4 level pain; and
10/1/17 at 9:00 am 10 level pain and 10:00 pm 8

F 600

discovery and a change in condition assessment will be initiated by licensed nursing staff and communicated to the physician and/or medical staff.

Licensed nurses, including weekend staff, agency and part time staff, were educated on 12/1/17 regarding awareness of complaints of increased or unresolved pain that is not managed by current medication regiment as well when to follow-up with physician and initiate a change in condition assessment. The CNE, ACNE, and UM will audit, through interviews, alert and oriented residents, five days per week including one weekend day x 4 weeks, two days per week including one weekend day x 4 weeks, then weekly x 4 weeks.

The CNE will review the findings of the audits and present findings to the QAPI team monthly for 3 months.

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F 600	Continued From page 14	F 600		

level pain

Nurses ' note dated 9/29/17 at 10:30 pm revealed Resident #1 complained of migrating back pain with spasms and numbness to finger tips. The NP was made aware and ordered for continued use of newly scheduled pain medications (Ibuprofen: anti-inflammatory).

Nurses ' note dated 9/30/17 at 2:30 am Resident #1 was provided Tizanidine HCL 6 mg as needed for back pain (muscle relaxer).

Nurses ' note dated 10/1/17 at 2:29 am Resident #1 was provided as needed Tizanidine HCL 6 mg for back pain.

Nurses ' note dated 10/1/17 at 6:56 am Resident #1 was provided as needed Tizanidine HCL 6 mg for back pain.

Nurses ' note dated 10/1/17 at 7:36 am Resident #1 complained he "can ' t stand the pain" and "requested to go to the hospital."

Nurse Practitioner (NP) progress note dated 10/1/17 revealed she received a voice mail from the facility at 7:26 am that Resident #1 requested to be sent to the hospital because of his back pain. The NP called the facility back at 9:13 am and ordered a urinalysis, urine culture and sensitivity, and a back x-ray and to be called when the results were available.

A review of the telephone/verbal order signature details dated 10/1/17 at 2:10 pm revealed the NP placed the order for x-ray of the lower back and lumbar spine.

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F 600	Continued From page 15	F 600		

NP progress note dated on 10/1/17 at 6:22 pm revealed the NP received a voice mail at 5:22 pm that Resident #1 was once again threatening to leave and go to the hospital due to his back pain. NP called the facility at 5:23 pm and was informed that the resident signed himself out and his family took him to the hospital. The note indicated the back x-ray and urinalysis had not been completed yet (in the facility).

A review of Resident #1 ' s hospital record dated 10/2/17 revealed the resident had a magnetic resonance imaging (MRI: scans inside of the body) which reported a lumbar epidural abscess and sepsis (infection in the blood). The resident was admitted to the hospital and treated for sepsis resulting from the spinal abscess and required surgery to remove the spinal epidural abscess and to provide a laminectomy (orthopedic procedure to remove the vertebral disc and fuse two spinal processes together).

A review of the NP progress note dated 10/2/17 revealed the family took Resident #1 to the Emergency Department (ED) for intractable back pain 10/1/17. The resident received Dilaudid (strong narcotic pain reliever), Decadron (steroid to reduce acute inflammation), and Toradol (strong prescription anti-inflammatory), had blood cultures drawn, and an order for a magnetic resonance imaging (MRI) the next morning. The resident informed the NP that he was crying like a baby because the pain was so bad, he could not take it anymore.

On 11/28/17 at 2:00 pm an interview was conducted with Resident #1. Resident #1 stated that he had several days of uncontrolled pain. The resident informed the nurse, the NP and his

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F 600	Continued From page 16	F 600		

family about the increased pain. The resident stated on 10/1/17 during the early morning the pain had gotten unbearable. The resident stated that he requested to go to the hospital several times because he knew something was wrong. The resident was informed by Nurse #1 that the NP refused to send him to the hospital after waiting all day for an answer. The resident called his family crying in pain to take him. The resident stated that his family took him to the hospital on 10/1/17 in the evening.

On 11/28/17 at 4:30 pm an interview was conducted with Nurse #1. Nurse #1 stated that she was assigned to Resident #1 on 9/28/17 the evening shift (3:00 pm to 11:30 pm). Nurse #1 stated that she was very familiar with the resident. Nurse #1 informed the NP at 11:59 pm that Resident #1 was having back pain 8 out of 10 scale that was not relieved with his regular scheduled medication. The NP ordered Ibuprofen 800 milligrams now one dose which was administered.

Nurse #1 stated that she was assigned to Resident #1 on 10/1/17 day shift (7am - 3:30 pm). The NP was called at 7:35 am and informed that the resident had increased acute back pain 10 out of 10 scale and this was a change. Nurse #1 stated that she received a call back from the NP toward the end of her day shift. The NP had ordered labs, back x-ray, and urinalysis and culture/sensitivity. Nurse #1 stated she informed the NP that the resident wanted to go to the hospital. According to Nurse #1, the NP replied, "I am not sending him to the hospital, he just wants more pain medication." Nurse #1 stated she informed the resident of the NP orders and the resident cursed and had become angry.

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F 600	Continued From page 17 Nurse #1 stated the resident informed her he "was not going to wait anymore" and was "going to call his family to take him" (to the ED). Nurse #1 stated that the resident had a right to go to the ED if he wanted. Nurse #1 stated that she had not waited almost an entire shift for a response from an NP in the past. Nurse #1 stated that she did not like to send a resident to the ED without an order. Nurse #1 stated that the Unit Manager was available 24 hours a day and she could have called her. Nurse #1 stated she would send a resident to the ED in an emergency via ambulance without an order if necessary. The next day during report Nurse #1 was informed that the resident ' s family came and took the resident to the ED. On 11/28/17 at 4:50 pm an interview was conducted with Nurse #2. Nurse #2 stated she could not remember Resident #1 and his complaints of increased back pain. Nurse #2 stated she was on duty on 9/29/17 evening and night shifts (3:00 pm to 7:00 am) responsible for the hall where Resident #1 resided. Nurse #2 stated that she was frequently assigned to different halls. On 11/28/17 at 5:28 pm an interview was conducted with the Medical Director (MD). The MD stated that he had reviewed Resident #1 ' s record and remembered him. The resident had pain management issues secondary to polysubstance abuse. The resident was on heavy medications: Gabapentin, Tizanidine, Ibuprofen, and Motrin. The MD stated the NP was called on 10/1/17 because of the resident ' s increased back pain. The NP ordered labs, UA, and back x-ray and chose not to transfer to the ED. The MD felt this plan was reasonable. The	F 600		

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F 600	Continued From page 18 resident had ongoing back pain and was difficult to assess. The resident would be up and smoking or sitting in his bed and not complaining of pain when the NP saw him on 9/28/17 and 9/29/17. The MD stated that it was a resident ' s right to go to the ED and that if the facility staff felt the resident had a significant change they could send the resident without an order. The MD agreed that if the resident was to go to the ED himself there would be no medical information from the facility provided. On 11/28/17 at 6:35 pm an interview was conducted with Nursing Assistant #1 (NA). The NA stated she was assigned to Resident #1 on 10/1/17 evening shift (3pm - 11:30 pm). The NA stated that the resident was "hurting real bad" and this was unusual for him. The resident had more pain than was previously seen and this was a change. The NA did not see the NP on evening shift. The NA stated that she was present when the resident ' s wife came to the facility and stated she was taking the resident to the ED. On 11/28/17 at 6:45 pm an interview was conducted with the Administrator. The Administrator stated that if a resident chose and requested to go to the hospital it was his/her right to be sent.	F 600		
F 675 SS=G	Quality of Life CFR(s): 483.24 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain	F 675		12/4/17

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the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.
This REQUIREMENT is not met as evidenced by:
Based on record review, resident interview, physician interview, and staff interviews, the facility failed to provide the resident requested care and services which resulted in uncontrolled pain management and a delay in medical treatment for sepsis and a spinal epidural abscess with nerve impingement in 1 out of 3 residents (Resident #1).

Findings included:

The resident was admitted on 9/5/17, discharged to the hospital 10/2/17 and readmitted to the facility on 10/27/17. The facility diagnoses were polysubstance abuse, osteomyelitis of vertebra thoracic, intra-spinal abscess, sepsis, thoracic discitis, and multiple back surgeries.

Resident #1's 14-day MDS dated 9/19/17 revealed the resident had an intact cognition, was not feeling depressed, and there was no psychosis or behavior. The resident was on scheduled and as needed pain medication regimen. The resident had frequent pain.
Resident #1 had a care plan dated 9/5/17 that included goals and interventions for pain. The pain was to be assessed each shift and pain medication administered as scheduled and as needed.

Pain medication orders were: Gabapentin 300 milligrams 3 times a day ordered on 9/12/17 (anti-seizure medication used for nerve pain);

F 675

In addition to the Plan of Correction (POC) submitted, we also respectfully submit the following. Our center is registered with North Carolina QIO and we have reached out to them for additional assistance and support related to this survey cycle. The QIO has scheduled a quality advisor to visit and assist in a broader QI plan for the center. It is our goal to utilize their expertise for process improvement related to compliance.

Resident #1 went to the hospital and received services on October 1st, 2017.

The CNE and ACNE completed 100% audit of all residents for the desire for transfer to the hospital. No residents were determined to have the desire for transfer to the hospital. Any resident who is identified for transfer to the hospital or who had a significant change in condition assessment, the physician will be notified at the time of discovery to avoid a delay in medical treatment.

Licensed nurses completed 100% pain assessment of all residents. No residents were determined to have unresolved or increased pain. If any resident verbalizes unresolved or increased pain, the physician will be notified at the time of

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F 675	Continued From page 20 Tizanidine 4 milligrams every 6 hours as needed for muscle spasm; Tylenol 1000 milligrams every 12 hours ordered on 9/27/17 (non-narcotic pain reliever); and Ibuprofen 800 milligrams 3 times a day ordered on 9/29/17 (anti-inflammatory). A review of the September and October 2017 medication administration record revealed documented pain level as follows: 9/28/18 at 9:00 am 0 level pain and 10:00 pm 8 level pain; 9/29/17 at 9 am 5 level pain and 10:00 pm 8 level pain; 9/30/17 at 9:00 am 10 level pain and 10:00 pm 4 level pain; and 10/1/17 at 9:00 am 10 level pain and 10:00 pm 8 level pain (level scale of 1 to 10 with 10 being the worst pain). Nurses' note dated 9/29/17 at 12:51 pm revealed Resident #1 had a pain assessment of 10 out of 10 almost constantly. The pain made it hard to sleep at night and caused limited day-to-day activities. The pain was documented as being new. The resident was not satisfied with his current level of pain. Nurses' note dated 9/29/17 at 10:30 pm revealed Resident #1 complained of migrating back pain with spasms and numbness to finger tips. The NP was made aware and ordered for continued use of newly scheduled pain medication (Ibuprofen). Nurses' note dated 9/30/17 at 2:30 am Resident #1 was provided Tizanidine HCL 6 mg as needed for back pain (muscle relaxer).	F 675	discovery to avoid a delay in medical treatment and a change in condition assessment will be initiated by licensed nursing staff and communicated to the physician and/or medical staff. Licensed nurses, including weekend staff, agency and part time staff, were educated on 12/1/17 regarding awareness of complaints of increased or unresolved pain that is not managed by current medication regimen as well as when to follow-up with physician and initiate a change in condition assessment. The CNE, ACNE and UM will audit, through interviews, alert and oriented residents, five days per week including one weekend day x 4 weeks, two days per week including one weekend day x 4 weeks, then weekly x 4 weeks. Licensed nurses, including weekend staff, agency and part time staff, were educated on 12/1/17 regarding honoring the residents' decision and request to be transferred to the hospital. The CNE, ACNE and UM will audit, through interviews, alert and oriented residents, five days per week including one weekend day x 4 weeks, two days per week including one weekend day x 4 weeks, then weekly x 4 weeks. The CNE will review the findings of the audits and present findings to the QAPI team monthly for 3 months.	

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Nurses' note dated 10/1/17 at 2:29 am Resident #1 was provided as needed Tizanidine HCL 6 mg for back pain.

Nurses' note dated 10/1/17 at 6:56 am Resident #1 was provided as needed Tizanidine HCL 6 mg for back pain.

Nurses' note dated 10/1/17 at 7:36 am Resident #1 complained he "can't stand the pain" and "requested to go to the hospital."

Nurse Practitioner (NP) progress note dated 10/1/17 revealed she received a voice mail from the facility at 7:26 am that Resident #1 requested to be sent to the hospital because of his back pain. The NP called the facility back at 9:13 am and ordered a urinalysis, urine culture and sensitivity, and a back x-ray and to be called when the results were available.

A review of the telephone/verbal order signature details dated 10/1/17 at 2:10 pm revealed the NP placed the order for x-ray of the lower back and lumbar spine.

NP progress note dated on 10/1/17 at 6:22 pm revealed the NP received a voice mail at 5:22 pm that Resident #1 was once again threatening to leave and go to the hospital due to his back pain. NP called the facility at 5:23 pm and was informed that the resident signed himself out and his family took him to the hospital. The note indicated the back x-ray and urinalysis had not been completed yet (in the facility).

A review of the Emergency Department (ED) record dated 10/1/17 revealed Resident #1 was diagnosed with intractable back pain. The

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F 675	Continued From page 22 resident had blood cultures drawn. The resident was treated for pain with Dilaudid (strong narcotic pain reliever), Decadron (steroid for acute inflammation), and Toradol (prescription anti-inflammatory) [pain medications not provided at the facility]. The neurosurgeon was consulted and a magnetic resonance image (MRI: scan of the body) of the lumber spine was ordered for the next morning to determine the cause of the back pain. A review of Resident #1's Hospital record dated 10/2/17 revealed the resident had an MRI which reported a lumbar epidural (spinal canal) abscess and sepsis (infection in the blood). The resident was admitted to the hospital and treated for an infection and required surgery to remove the spinal epidural abscess and to provide a laminectomy (orthopedic procedure to remove the vertebral disc and fuse two spinal processes together). A review of the NP progress note dated 10/2/17 revealed the family took Resident #1 to the ED for intractable back pain 10/1/17. The resident received Dilaudid, Decadron and Toradol (pain medications) and an order for an MRI the next morning. The resident informed the NP that he was crying like a baby because the pain was so bad, he could not take it anymore. On 11/28/17 at 2:00 pm an interview was conducted with Resident #1. Resident #1 stated that he had several days of uncontrolled pain. The resident informed the nurse, the NP and his family about the increased pain. The resident stated on 10/1/17 during the early morning the pain had gotten unbearable. The resident stated that he requested to go to the hospital several	F 675		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. BUILDING ______ B. WING ______	C 11/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN CENTER	707 NORTH ELM STREET HIGH POINT, NC 27262

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F 675		F 675		

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times because he knew something was wrong. The resident was informed the NP refused to send him to the hospital after waiting all day for an answer. The resident called his family crying in pain to take him. The resident stated that his family took him to the hospital on 10/1/17 in the evening.

On 11/28/17 at 4:30 pm an interview was conducted with Nurse #1. Nurse #1 stated that she was assigned to Resident #1 on 9/28/17 the evening shift (3:00 pm to 11:30 pm). Nurse #1 stated that she was very familiar with the resident. Nurse #1 informed the NP at 11:59 pm that Resident #1 was having back pain 8 out of 10 scale that was not relieved with his regular scheduled medication. The NP ordered Ibuprofen 800 milligrams now one dose which was administered.

Nurse #1 stated that she was assigned to Resident #1 on 10/1/17 day shift (7am - 3:30 pm). The NP was called at 7:35 am and informed that the resident had increased acute back pain 10 out of 10 scale and this was a change. Nurse #1 stated that she received a call back from the NP toward the end of her day shift. The NP had ordered labs, back x-ray, and urinalysis and culture/sensitivity. Nurse #1 stated she informed the NP that the resident wanted to go to the hospital. According to Nurse #1, the NP replied, "I am not sending him to the hospital, he just wants more pain medication." Nurse #1 stated she informed the resident of the NP orders and the resident cursed and had become angry. Nurse #1 stated the resident informed her he "was not going to wait anymore" and was "going to call his family to take him" (to the ED). Nurse #1 stated that the resident had a right to go to the

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F 675	Continued From page 24	F 675		

ED if he wanted. Nurse #1 stated that she had not waited almost an entire shift for a response from an NP in the past. Nurse #1 stated that she did not like to send a resident to the ED without an order. Nurse #1 stated that the Unit Manager was available 24 hours a day and she could have called her if there was a concern. Nurse #1 stated she would send a resident to the ED in an emergency via ambulance without an order if necessary. The next day during report Nurse #1 was informed that the resident's family came and took the resident to the ED.

On 11/28/17 at 5:28 pm an interview was conducted with the Medical Director (MD). The MD stated that he had reviewed Resident #1's record and remembered him. The resident had pain management issues secondary to polysubstance abuse. The MD stated the NP was called on 10/1/17 because of the resident's increased back pain. The NP ordered labs, urinalysis, and back x-ray and chose not to transfer to the ED. The resident had ongoing back pain and was difficult to assess. The MD stated that it was a resident's right to go to the ED and that if the facility staff felt the resident had a significant change they could send the resident without an order. The MD agreed that if the resident was to go to the ED himself there would be no medical information from the facility provided.

On 11/28/17 at 6:35 pm an interview was conducted with Nursing Assistant #1 (NA). The NA stated she was assigned to Resident #1 on 10/1/17 evening shift (3pm - 11:30 pm). The NA stated that the resident was "hurting real bad" and this was unusual for him. The resident had more pain than was previously seen and this was a

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F 675	Continued From page 25 change. The NA did not see the NP on evening shift. The NA stated that she was present when the resident's wife came to the facility and stated she was taking the resident to the ED. On 11/28/17 at 6:45 pm an interview was conducted with the Administrator. The Administrator stated that if a resident chose and requested to go to the hospital it was his/her right to be sent.	F 675		