STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345036	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH CITY HEALTH AND REHABILITATION	1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909

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F 000	INITIAL COMMENTS The on-site investigation was completed on 11/30/17 but the complaint left open due to the need for additional interviews with former staff that were not available during the on-site investigation. Thervey was closed on 12/1/17 after these interviews were completed.. The complaint allegations were not substantiated.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions.	F 636		12/22/17

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

Electronically Signed | 12/15/2017

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F 636	Continued From page 1 (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Registered Dietician interviews, the facility failed to comprehensively assess a resident with a new feeding tube for fluid and nutritional requirements for 1 of 3 sampled residents with a feeding tube (Resident #2).	F 636	Elizabeth City Health and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules	

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F 636	Continued From page 2 The findings included: Resident #2 was originally admitted to the facility on 12/2/16 and had a diagnosis of anemia, hypertension, diabetes, chronic respiratory failure, congestive heart failure, myocardial infarction (heart attack), chronic kidney disease and cerebrovascular accident (stroke) with left sided weakness. Review of the clinical record revealed the resident was admitted to the hospital on 9/20/17. The hospital discharge summary dated 11/12/17 noted the resident was treated for pneumonia and sepsis (blood infection), was not eating and the decision was made to insert a feeding tube. The hospital discharge orders dated 10/12/17 revealed a physician ' s order that read: "Diet as Follows: Tube feed: Glucerna 1.5 @ (at) 25-40mls (milliliters) per hour." There were no orders for water flushes. A physician ' s telephone order dated 10/12/17 revealed an order for Glucerna 1.5 continuous via PEG (Percutaneous Endoscopic Gastrostomy tube or feeding tube) at 40mls per hour with 30mls water flush every 3 hours. There was a physician ' s order dated 10/13/17 to check tube feeding residual (amount of fluid in the stomach) every 3 hours and hold feeding for 2 hours if residual is greater than 50ml. A physician ' s progress note dated 10/14/17 noted the resident was re-admitted to the facility on 10/12/17. The note revealed the resident had a long history of dysphagia (difficulty swallowing) and got a PEG tube placed. The assessment	F 636	and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Elizabeth City Health and Rehabilitation response to the Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Elizabeth City Health and Rehabilitation reserves the right to refuse refute any of the deficiencies on this statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F636 COMPREHENSIVE ASSISSMENTS & TIMING Elizabeth City Health and Rehabilitation conducts initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident’s functional capacity including assessing a resident with a new feeding tube for fluid and nutritional requirements. 1. The corrective action accomplished for Resident #2 is new orders were received on 12/1/17 for a blood draw for a Basic Metabolic Panel, Magnesium level, and Complete Blood Count on 12/4/17. Resident #2 was assessed on 12/4/17 by the Unit Manager and revealed no signs or symptoms of dehydration. Results of the blood testing were received on 12/4/17 and reviewed by the resident’s physician on 12/5/17 with no new orders.	

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F 636	Continued From page 3 noted a chronically debilitated resident that now had a PEG tube for dysphagia and aspiration risk, sepsis on her last hospital admission. The Plan was to continue current treatment. Will have the dietician monitor for needs, try to keep her weight down and sugars and electrolytes good and monitor labs. The note revealed the resident ' s long-term prognosis was obviously guarded at best given all of her numerous problems. A Significant Change Minimum Data Set (MDS) Assessment dated 10/19/17 revealed the resident had severe cognitive impairment and had a feeding tube that provided over 51 percent of calories and fluids daily. The MDS revealed the resident received insulin injections for 7 days and a diuretic (fluid pill) for 7 days of the 7 day assessment period. A dietary evaluation dated 10/23/17 revealed the following: Received consult from RN (Registered Nurse) regarding a concern over elevated glucose levels. She is currently NPO (nothing by mouth). Diet: Glucerna 1.5 (tube feeding formula) at 40mls per hour with 30ml water flush every 3 hours. Glucose levels are checked four times a day and have ranged from 175-346. Assessment: Resident is at the upper end of an obese weight range per her BMI (Body Mass Index). Skin is intact. Medications noted. Nutrient needs assessed at approximately 1600-1800 kilocalories, 80-90 grams protein and 1700-1900 mls fluid per day based on 30ml per kilogram weight. Current tube feeding provides 1440 kilocalories, 80 grams protein and 968 ml fluids per day (free fluid and flushes). All glucose levels are elevated. Diabetes is treated with Lantus insulin only. Physician increased dosage of insulin from 24 units per day to 30 units per day	F 636	The Registered Dietician reviewed on 12/6/17 Resident #2 for hydration needs and no new recommendations were received. Through Root Cause Analysis the Quality Assurance Performance Improvement Committee (QAPIC) identified the following processes needed improvement the communication of the Dietary Manager notifying the Registered Dietician (RD) of the physician's order of 10/14/17 for review of the resident. There was no system in place to assure dietary referral orders were carried out. Also there was no clear communication the Admitting Nurse to make a RD referral when a resident is admitted or re-admitted with an order for a resident to be feed by tube feeding. 2. The measures put in place or systemic changes made are: 100% audit of resident's with a gastrostomy tube was reviewed by the Registered Dietician for hydration needs on 12/6/17 and 12/13/17 with no concerns or new recommendations. The process of how the Registered Dietitian will be notified of physician orders, admission/re-admitted to the facility with a feeding tube of nutritional and hydration is a new communication form is completed by admitting Charge Nurse and copies are given to Unit Manager and Registered Dietitian. During Morning Meeting the orders are reviewed and checked to ensure the communication was completed and given to the Registered Dietitian. The	

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F 636	Continued From page 4 on 10/22/17, however, levels remain elevated. Plan: Recommend to continue with current enteral feeding rate for present time. Agree with contacting physician regarding continued elevated glucose levels (question need for additional insulin). An interview was conducted with the Director of Nursing (DON) and the Nurse Consultant on 11/30/17 at 9:35 AM. The DON stated when a resident was admitted to the facility with a feeding tube, a referral form was filled out and sent to dietary for the RD to evaluate the resident ' s nutritional needs. The DON further stated the RD comes in every Wednesday for a weight meeting and followed up with any new referrals that day. The DON stated the RD would have come in on Wednesday 10/18/17 to see new referrals. There were no RD notes for this resident from 10/12/17 (day of admission) until 10/23/17. In a separate interview on 11/30/17 at 11:42 AM, the DON stated she did not know why the resident was not seen by the RD prior to 10/23/17. The DON further stated the nurse that admitted the resident on 10/12/17 (Thursday) should have filled out and sent a RD referral form to dietary and the RD would pick up the referrals when she came in on Wednesday 10/18/17. The DON stated the resident should have been evaluated by the RD on 10/18/17. The Registered Dietician (RD) stated in an interview on 11/30/17 at 12:30 PM she was in the facility every Wednesday and would see any new referrals. The RD stated she received a referral via E-mail on 10/23/17 due to the resident ' s elevated blood sugars and she came in on the same day to evaluate the resident. The RD stated	F 636	Director of Nursing (DON) ensures the process is completed. The DON initiated an in-service on 12/13/17 to the Dietary Manager and licensed nurses to send a referral to the Registered Dietician for each resident admitted/re-admitted to the facility with a feeding tube for nutritional and hydration needs and any physician's orders written for a Registered Dietician review. A copy of all Dietician referrals will be sent to the Unit Managers as notification that the referral was sent. In-servicing will be completed by 12/22/17. All newly hired licensed staff will receive the education during onboarding. The Registered Dietician will forward a copy of her recommendations to the Administrator, DON, Unit Managers, Minimum Data Set Nurse, and Dietary Manager. 3. Elizabeth City Health and Rehabilitation will monitor the corrective plan to ensure the practice was corrective and will not reoccur is Utilizing a Quality Improvement (QI) Audit Tool, the Unit Managers will review all Physicians' orders for Registered Dietician referrals and for any admitted/re-admitted residents with a feeding tube and verify a referral was sent to the Registered Dietician Monday through Friday for 2 weeks, then twice weekly for 2 weeks, then weekly for 4 weeks, then monthly for 1 month. The Weekend Supervisor will review all Dietician referrals and newly admitted residents with a feeding tube for 2 weekends, then every other weekend for 1 month, then one weekend monthly	

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F 636	Continued From page 5 this was the first referral she received for Resident #2 since the resident received the feeding tube. An interview was conducted on 11/30/17 at 3:20 PM with Nurse #1 who was assigned to Resident #2 at the time of admission. Nurse #1 stated the admission nurse filled out the referrals for the RD and she did not fill out a RD referral for Resident #2 when the resident was re-admitted to the facility on 10/12/17. In a separate interview with the Registered Dietician (RD) on 11/30/17 at 4:51 PM, the RD stated when she saw Resident #2 on 10/23/17 the resident had increased residuals (too much fluid in the stomach) and was reluctant to increase her tube feeding or water flushes due to the resident ' s increased risk for aspiration. An interview was conducted on 12/1/17 at 11:35 AM with the Admission Nurse that admitted Resident #2 to the facility on 10/12/17. The Admission Nurse stated the nurses on the hall did the referrals for the RD to see the residents. The Nurse stated she was not aware that a RD referral form existed and did not complete one for Resident #2 when re-admitted to the facility on 10/12/17.	F 636	for 2 months. The Director of Nursing will review and initial the audit tools weekly for 4 weeks, then every other week for 2 months, ant then monthly for one month to monitor trends or concerns. 4. The DON will be responsible for implementing the plan of correction. The DON will report the results of the monitoring at monthly QAPIC meeting for 3 months for trends and recommendations for any modification of the process. 5. The correction date for substantial compliance is December 22, 2017.	