STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. BUILDING _____ B. WING _____	C 07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE NURSING AND REHABILITATION CENTER	**711 SUSAN TART ROAD DUNN, NC 28335**

(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 A complaint survey was conducted from 7/8/19 to 7/9/19. One of the eight allegations was substantiated.	F 000		
F 580 SS=D	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. (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	F 580		8/6/19

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

Electronically Signed | 07/25/2019

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F 580	Continued From page 1 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, family interview, staff interview, and physician interview the facility failed to notify the responsible party when the resident was started on a new medication for behavioral problems for one (Resident # 1) of one sampled resident reviewed for family notification. The findings included: Record review revealed Resident # 1 resided at the facility from 5/17/19 to 6/16/19. The resident had diagnoses of vascular dementia with behavioral disturbance, cognitive communication deficit, and anxiety with adjustment disorder. Review of Resident # 1's admission MDS (Minimum Data Set) assessment, dated 5/24/19, revealed the resident was cognitively impaired. The resident was also assessed to have both mood and behavior problems. Further review of Resident # 1's record revealed	F 580	F580 □ Notify of Changes Cornerstone Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Cornerstone Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Cornerstone Nursing and Rehabilitation Center reserves the right to refute any of	

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F 580	Continued From page 2 a medical physician's telephone order, dated 6/4/19, for the resident to have a psychological evaluation and treatment due to combative behavior, adjustment problems, and confusion. Record review revealed a Psychiatric Mental Health Nurse Practitioner (PMHNP) saw the resident on 6/4/19 and ordered Resident # 1 to start on Namenda 5 mg (milligrams) for one week and then for the dosage to be increased to 5 mg twice per day for his vascular dementia. Review of the record revealed no documentation that the responsible party was informed of the new Namenda medication orders by the PMHNP, the attending physician, or by the nursing staff before the medication was started. Review of Resident # 1's care plan, dated 6/11/19, revealed multiple behavioral problems which included: trouble in remembering, comprehending, and relaxing; wandering; disrobing; verbalization of desire to die; verbalization of desire to kill his family; and displaying sexual behavior towards staff members. One of the care plan approaches was to obtain a psychological consult if ordered by MD. The care plan noted that the resident's son had previously declined psychological services and medications to improve behaviors. Resident # 1's responsible party (RP)was interviewed on 7/8/19 at 11:07 AM. The RP stated while Resident # 1 was at the facility, the staff had talked to him about having a psychiatric nurse see Resident # 1. The RP stated he had wanted all of Resident # 1's medication changes to come	F 580	the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Resident #1 no longer resides in the facility. On 07/24/2019, a 100% audit of all new orders for the last 30 days was initiated by the director of nursing (DON) and/or designee to ensure that new orders for medications have included documented notification of the resident representative (RR) in the electronic health record. The DON and/or designee will immediately correct any areas of concern. The audit will be completed by 08/06/19. On 07/24/2019, an in-service was initiated by the staff facilitator with nurses on Notification of Resident Representative of New Medication Orders. The in-service will be completed by 08/06/19. The unit manager and/or designee will monitor all new orders utilizing the RR Notification Audit Tool to ensure that new orders for medications have documented notification of the resident representative in the electronic health record. The RR Notification Audit Tool will be completed five (5) days a week for four (4) weeks and then weekly for four (4) weeks. The unit manager and/or designee will immediately address all identified areas of concern. The DON will review and initial the RR Notification Audit Tool five (5) days a week for four (4) weeks and then weekly for four (4) weeks to ensure that new	

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F 580	Continued From page 3 directly from the attending physician, and he conveyed this to the staff. The RP stated he later found the psychiatric nurse saw Resident # 1, and there was an adjustment made in the resident's medication of which he (the RP) was not informed when it was done, and he had wanted to know about medication changes. Interview with the Director of Nursing on 7/9/19 at 4:20 PM revealed the nursing staff would place a nursing note in the record when a responsible party was informed of medication changes. It was confirmed with the DON on 7/9/19 at 4:20 PM that there was no documentation Resident #1's RP was informed of the Namenda when the order was initiated. Interview with Resident # 1's physician on 7/9/19 at 4:10 PM revealed he felt the Namenda had been an appropriate medication for Resident # 1, and the medication had not adversely affected the resident.	F 580	orders for medications have documented notification of resident representative. The DON will forward the results and trends of the RR Notification Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for two (2) months. The QAPI Committee will meet monthly for two (2) months and review the RR Notification Audit Tool to determine trends and/or issues that may need further interventions and/or frequency of monitoring.	
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders.	F 773		8/6/19

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F 773	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, family interview, and physician interview for one (Resident # 1) of one sampled resident whose labs were reviewed, the facility failed to notify the physician on the day the resident's white blood count returned as abnormal. The findings included: Record review revealed Resident # 1 resided at the facility from 5/17/19 to 6/16/19. The resident had diagnoses of vascular dementia, prostate cancer, cognitive communication deficit, hypertension, anxiety with adjustment disorder, muscle weakness with a history of falls, and emphysema. Review of Resident # 1's admission MDS (Minimum Data Set) assessment, dated 5/24/19, revealed the resident was cognitively impaired and needed extensive assistance with his activities of daily living. Review of Resident # 1's orders revealed a physician's verbal order was given on 6/13/19 at 1:25 PM to obtain a CBC (complete blood count). Review of lab results revealed the blood work was completed on 6/14/19. At the top of the CBC report it was noted the results were reported on 6/14/19 at 3:06 PM. The CBC results showed the resident's WBC (white blood count) was 16.6 and a normal range was 3.8 to 10.8. (An elevated WBC at times may indicate a possible infection). There was no documentation in the resident's record the lab result was called to the physician on 6/14/19.	F 773	F773- Lab Services Physician Order/Notify of Results Cornerstone Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Cornerstone Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Cornerstone Nursing and Rehabilitation Center reserves the right to 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. Resident #1 no longer resides in the facility. On 07/08/2019, a 100% audit of all lab results in the last 30 days was initiated by the director of nursing (DON) and/or designee to ensure all labs with abnormal values resulted in notification of the physician on the day the facility received the results. The DON and/or designee	

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F 773	Continued From page 5 Interview with the resident's responsible party on 7/8/19 at 11:07 AM revealed he had visited Resident # 1 on the afternoon of 6/15/19. He talked to a nurse, who went to review Resident # 1's medical record. The responsible party stated the nurse returned and informed him Resident # 1's lab work had shown he might have an infection, and the physician had not yet been notified. The responsible party did not know why the physician had not been called about the abnormal lab work. Nurse # 1 was interviewed on 7/8/19 at 2:10 PM and again on 7/9/19 at 3:00 PM. Nurse # 1 had cared for Resident # 1 on 6/15/19. Nurse # 1 reported the following. No one had mentioned to her in the 6/15/19 nursing report that Resident # 1's lab work was abnormal and there needed to be follow up. She was not aware of this until the family visited and started questioning her about the resident's status. When the family conveyed a concern, she went to review the resident's record and saw that his lab work had returned the previous day as abnormal, but no one had called the physician. She immediately called the physician, who ordered antibiotics and a chest x-ray. The DON was interviewed on 7/9/19 at 8:30 AM and reported the following regarding the facility's lab system. When a routine lab is ordered, then it is drawn the next morning. The results are then sent to the facility by a computerized system. The nursing supervisor is to daily review the list of morning drawn labs and check the computer to assure the lab results come in. The nursing supervisor then assures the hall nurse is informed of lab abnormalities, and the hall nurse notifies the physician. The DON stated it was her	F 773	will immediately address any areas of concern identified by the audit. The audit will be completed by 08/06/19. On 07/24/2019, an in-service was initiated by the staff facilitator with nurses on Notification of Abnormal Labs. The in-service will be completed by 08/06/19. The unit manager and/or designee will monitor all lab results utilizing the Abnormal Lab Audit Tool to ensure that all labs with abnormal values have physician notification on the day the facility receives the results. The Abnormal Lab Audit Tool will be completed five (5) days a week for four (4) weeks and then weekly for four (4) weeks. The DON will review and initial the Abnormal Lab Audit Tool five (5) days a week for four (4) weeks and then weekly for four (4) weeks to ensure that new orders for medications have documented notification of responsible party. The DON will forward the results and trends of the Abnormal Lab Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for two (2) months. The QAPI Committee will meet monthly for two (2) months and review the Abnormal Lab Audit Tool to determine trends and/or issues that may need further interventions and/or frequency of monitoring.	

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F 773	Continued From page 6 expectation that Resident # 1's abnormal WBC result should have been called to the physician on the afternoon of 6/14/19. The DON stated she had talked to the nursing supervisor on 7/8/19, and the nursing supervisor could not recall why the physician was not consulted regarding the abnormal lab on 6/14/19. The resident's physician was interviewed on 7/9/19 at 4:10 PM and confirmed that if he had been called on 6/14/19 he would have ordered the resident to start antibiotics on 6/14/19. The physician stated it was his medical opinion, that although he would have started treatment earlier on 6/14/19, this would not have resulted in a different outcome to Resident # 1.	F 773		