STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345253	A. BUILDING _____ B. WING _____	C 06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEYSTONE HEALTH & REHABILITATION	80 BROWNSBERGER CIRCLE FLETCHER, NC 28732

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F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interviews and medical record review, the facility failed to notify the physician of a	F 157	The plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. It is the policy of this facility that the charge nurse and / or physician be notified of any significant change at the time that said change occurs. A. On the day the observation occurred with resident #1, documentation of vital signs was obtained and neuro checks were done per hospital discharge orders. It is our policy now that anyone on neuro checks with any significant abnormalities of their vital signs will be reported to the nurse on call, the DON and the resident's physician.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: D O Smith — TITLE: administrator — (X6) DATE: 7/8/11

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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F 157	Continued From page 1 significant change in condition for one (1) of five (5) residents (Resident #1). The findings are: Resident #1 was admitted to the facility on 09/04/08 with diagnoses including Congestive Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF). The latest Minimum Data Set (MDS) dated 11/30/10 indicated that Resident #1 was cognitively intact for daily decision making and was able to make her needs known. Review of the facility's form "Release of Responsibility for Leave of Absence" revealed Resident #1's responsible party signed the resident out of the facility on 12/22/10 at 10:00 AM. Review of a nurse's note dated 12/25/10 revealed the facility received a telephone call the hospital requesting the resident's medication records. The facility was informed the resident had been in a motor vehicle accident. Review of hospital records indicated Resident #1 presented to the Emergency Room (ER) on 12/25/10 at 12:50 PM for evaluation after being involved in a motor vehicle accident. The hospital records further revealed Resident #1 was discharged that evening from the ER to the facility with instructions to check vital signs every shift and neurological checks for three (3) days. Review of the facility's Neurological Assessment Flow Sheet indicated Resident #1's neurological checks were continued per ER follow up	F 157	B. All residents that had neuro checks with vital signs done from January through June were audited with no abnormal findings noted. C. All licensed nursing staff have been educated on the importance of neuro checks and what abnormal vital signs should be reported to the resident's physician. A review was also done with all CNA's on the correct way to obtain vital signs with an emphasis on abnormal results and that all vital signs are communicated to the charge nurse. D. The DON will conduct a weekly audit of all daily vital signs and neuro checks if any are done, for any abnormal issues. This will be done times 4 weeks and then monthly times 2. Results will be documented and submitted to the Quality Assurance Committee for further review and corrective action if needed.	7/12/11

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F 157	Continued From page 2	F 157		

instructions. Review of vital signs recorded from 12/25/10 at 7:40 PM through 12/26/10 at 6:40 AM revealed parameters from 100/50 to 132/74. At 10:40 AM the nurse documented a BP of 71/51 and at 2:40 PM a BP of 70/49. No other neurological changes were noted during this time.

A nurse's note dated 12/26/10 at 9:30 PM revealed Resident #1 was pale, difficult to arouse and appeared confused with minimal verbal response. The resident's BP was documented as 110/40. Documentation further revealed the on-call nurse practitioner was notified on 12/26/10 at 9:30 PM of Resident #1's condition and an order was received to transfer the resident to the hospital.

Review of the hospital discharge summary dated 12/28/10 revealed Resident #1 was admitted back to the hospital on 12/27/10. She expired on 12/28/10 from respiratory failure secondary to pulmonary fibrosis and chest wall contusion/pulmonary contusion.

A telephone interview on 6/13/11 at 9:50 AM with Licensed Nurse (LN) #1 revealed she worked with Resident #1 on 12/26/10 during the 7:00 AM to 7:00 PM shift. When asked, LN #1 stated she should have called the physician with the BP readings of 71/51 and 70/49.

An interview on 6/13/11 at 10:30 AM with Resident #1's physician revealed he expected the LN to use their clinical judgment when assessing residents. If a resident's systolic pressure (top number of a blood pressure reading) was in the 70s, he would expect to be notified. The physician further revealed Resident #1's outcome would not

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F 157	Continued From page 3 have been any different had she been sent to the hospital after the first change in blood pressure. Resident #1 was a Do Not Resuscitate (DNR) and would have required intubation once admitted to the hospital. On 6/13/11 at 11:10 AM, the Nurse Practitioner (NP) on call for the facility on 12/26/10 indicated she should have been called after the first abnormal BP on 12/26/10 at 10:40 AM. The NP stated she was not notified of Resident #1's change in condition prior to 12/26/10 at 9:30 PM. An interview with the Director of Nursing (DON) on 6/14/11 at 11:00 AM revealed she would expect a nurse to notify the doctor of a change, concern or abnormality in any section of the neurological assessment.	F 157		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews and medical record review, the facility failed to assess a significant change in condition for one (1) of five (5) residents (Resident #1). The findings are:	F 309		

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F 309	Continued From page 4 Resident #1 was admitted to the facility on 09/04/08 with diagnoses including Congestive Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF). The latest Minimum Data Set (MDS) dated 11/30/10 indicated that Resident #1 was cognitively intact for daily decision making and was able to make her needs known. Review of hospital records indicated Resident #1 presented to the Emergency Room (ER) on 12/25/10 at 12:50 PM for evaluation after being involved in a motor vehicle accident. The hospital records further revealed Resident #1 was discharged that evening from the ER to the facility with instructions to check vital signs every shift and neurological checks for three (3) days. Review of the facility's Neurological Assessment Flow Sheet indicated Resident #1's neurological checks were continued per ER follow up instructions. Review of vital signs recorded from 12/25/10 at 7:40 PM through 12/26/10 at 6:40 AM revealed parameters from 100/50 to 132/74. At 10:40 AM the nurse documented a BP of 71/51 and at 2:40 PM a BP of 70/49. No other neurological changes were noted during this time. A nurse's noted dated 12/26/10 at 9:30 PM revealed Resident #1 was pale, difficult to arouse and appeared confused with minimal verbal response. Documentation further revealed the on-call nurse practitioner was notified of Resident #1's condition and an order was received to transfer the resident to the hospital. Review of the hospital discharge summary dated	F 309	It is the policy of this facility to assess a significant change in condition of a resident and take the appropriate action to provide care for highest well being. A. On the day the observation occurred with resident #1, documentation of vital signs were obtained and neuro checks with vital signs were done per hospital discharge orders. It is the policy of this facility now that anyone on neuro checks also receive a full assessment with documentation in the nurse's notes. All significant abnormalities well be reported to the DON or administrative nurse on call and to the physician. B. All residents that had neuro checks with vital signs done from January through June were audited with no abnormal findings noted.	

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F 309	Continued From page 5 12/28/10 revealed Resident #1 was admitted back to the hospital on 12/27/10. She expired on 12/28/10 from respiratory failure secondary to pulmonary fibrosis and chest wall contusion/pulmonary contusion. A telephone interview on 6/13/11 at 9:50 AM with Licensed Nurse (LN) #1 revealed she worked with Resident #1 on 12/26/10 during the 7:00 AM to 7:00 PM shift. When asked, LN #1 stated she should have called the physician with the BP readings of 71/51 and 70/49. An additional interview with LN #1 on 6/14/11 at 10:00 AM indicated she was aware that Resident #1 had been in an automobile accident on 12/25/10 and further revealed she had not reviewed the follow up instructions from the ER. LN #1 indicated she would consider a systolic (top reading) BP under eighty (80) to be low and a diastolic (bottom reading) BP under sixty (60) to be abnormal but did not recall reviewing Resident #1's vital signs. LN #1 acknowledged she did not provide narrative notes on 12/26/10 during the 7:00 AM to 7:00 PM shift. LN #1 confirmed if she had assessed the resident for any concerns, she would have documented the findings in the narrative note.	F 309	C. All licensed nursing staff have been educated on acute change of condition and have received a booklet outlining appropriate signs and symptoms of acute changes as noted in the AMDA clinical practice guidelines in the long term care setting. D. The DON will conduct a weekly audit of all daily vital signs and neuro checks if any are done for any abnormal issues. This will be done times 4 weeks and then monthly times 2. Results will be documented and submitted to the Quality Assurance Committee for further review and corrective action if needed.	7/12/11