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	345161	A. BUILDING _____ B. WING _____	R 07/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERNETHY LAURELS	102 LEONARD AVENUE NEWTON, NC 28658

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F 309 SS=G	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 observations, staff interviews and record reviews facility staff failed to assess or reassess for pain before or during a dressing change and failed to provide wound treatment according to physician's orders in one (1) of four (4) sampled residents for pressure sores/ulcers (Resident #6). The findings are: Resident #6 was admitted with diagnoses including high blood pressure, heart failure, peripheral vascular disease (a narrowing of blood vessels that restricts blood flow in the legs) and ischemia (an insufficient supply of blood due to a blocked artery) in the right (R) lower leg. The most recent annual Minimum Data Set (MDS) dated 5/9/12 indicated impairment in short and long term memory and moderate impairment in cognition for daily decision making. The MDS also indicated under section J titled "pain" that Resident #6 received scheduled pain medication, frequently had pain, pain affected her functioning and the pain intensity over a five (5) day period	F 309	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Abernethy Laurels of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law, and because the facility has been threatened with termination from the Medicare and Medicaid programs if it fails to do so. The facility contends that it was in substantial compliance with all requirements on the survey date, and denies that any deficiency exists or existed or that any such plan is necessary. Neither the submission of such plan, nor anything contained in the plan, should be construed as an admission of any deficiency, or of any allegation contained in this survey report. The facility has not waived any of its rights to contest any of these allegations or any other allegation or action. This plan of correction serves as the allegation of substantial compliance. Prefix Tag: 309 1) Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice. Resident #6 was seen by Vascular Surgeon on 7/19/2012 who made no	8/8/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kristi Harris — TITLE: NHA — (X6) DATE: 8/7/2012

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 309	Continued From page 1 was eight (8) out of ten (10) on a pain scale. A review of a care plan with goals dated through 8/31/12 indicated a problem statement that resident had developed a venous stasis ulcer to the right (R) lower extremity. The goals indicated Resident #6 would show signs of improvement in the next 90 days. The approaches indicated to provide treatment as ordered and assess for pain and medicate as needed or ordered. A review of a post-op/follow-up surgeon's note dated 7/6/12 indicated resident returned in follow-up to help control infection in the ulcers of her (R) lower extremity and continued to have significant pain. The plan indicated to continue Silvadene daily and add Ibuprofen 800 milligrams orally twice a day. A review of a nurse's note dated 7/11/12 at 5:10 PM indicated a treatment nurse assessed Resident #6's (R) lower extremity with increased slough (a layer of dead tissue) with an area that measured 2 centimeters (cm) x 0.5 cm x 0 cm at one (1) to three (3) o'clock with black eschar (a black scab) on back of lower leg wound and odor. Also noted a new open area 8 cm x 7 cm x 0.1 cm to (R) lower leg on (R) side. Will notify surgeon in the morning because office was closed. A review of a nurse's note dated 7/12/12 at 10:45 AM indicated the treatment nurse called the surgeon's office regarding her assessment of Resident #6's right lower leg on 7/11/12 and was informed that the surgeon saw Resident #6 this morning and she had a follow up appointment next week.	F 309	order changes. On 7/21/2012, the attending physician ordered Roxinol for pain. On 7/26/2012 Roxinol was d/c'd due to increased lethargy and loss of appetite. A Duragesic patch was ordered on 7/26/2012. On 8/2/2012 Roxinol was started again due to swallow difficulty. Motrin and Percocet continue scheduled daily. Percocet and Ultram continue PRN. Pain is being assessed and documented on the MARs. Assessment of pain prior to, during and after dressing change has been added to the Wound Care Nurse Treatment Record form and is being documented accordingly. Resident #6 had an order for Silvadene cream during treatments. Silvadene cream was on the TAR and Nurses who were giving daily treatments were using it as ordered. The Wound Care Nurse Treatment Book was updated to reflect the original order for Silvadene cream. <u>2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice:</u> All Wound Care Nurse Treatment Record forms were updated to include pain assessments prior to, during and after dressing changes beginning on August 1, 2012..	8/8/12

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F 309	Continued From page 2 A review of a physician's progress note dated 7/13/12 indicated Resident #6 had an ischemic (R) leg with progressive ulceration and worsening with eschar (a black scab) and odor and complaints of pain in (R) lower extremity. The resident is followed by a surgeon and no longer on antibiotics. The notes further indicated worsening wound and awaiting surgeon's instructions. A review of monthly physicians orders dated 7/1/12 through 7/31/12 indicated Motrin 800 milligrams by mouth twice a day for leg pain; Percocet 10-325 milligrams by mouth every eight (8) hours for pain; Percocet 5-325 milligrams by mouth one (1) to two (2) tablets every four hours as needed for pain and Ultram 50 milligrams by mouth twice daily as needed for pain. The orders further indicated to apply Silvadene cream daily to (R) lower extremity, cover with cepafoam and kerlix. A review of the monthly Medication Administration Record (MAR) dated 7/1/12 through 7/31/12 indicated Resident #6 received Motrin 800 milligrams by mouth at 8:00 AM and 4:00 PM daily and Percocet 10-325 milligrams by mouth at 6:00 AM, 2:00 PM and 10:00 PM daily. A review of "Nurse's Medication Notes" on the MAR dated 7/4/12 through 7/18/12 indicated Resident #6 had not received any doses of Ultram 50 milligrams by mouth for pain but received Percocet 5-325 milligrams by mouth for (R) leg pain. There was no documentation on the MAR of Resident 6's pain levels according to a pain scale of one (1) least pain to ten (10) worst	F 309	All orders have been reviewed to ensure they are included in the Wound Care Nurse Treatment book as specified. In-service education was conducted by the Director of Nursing with all licensed nurses who were on duty on 7/26/2012 regarding pain assessments. It was emphasized that anyone receiving treatments be assessed for pain prior to, during and after the treatment. Further directed in-service education was conducted on 8/6/2012 with licensed nurses by the Director of Nursing regarding: pain scales, following orders, and wound care protocols as updated. The Wound Care Nurse was educated on 8/6/2012 regarding having complete orders in the Treatment Record book she uses on each unit. LN #1 received one-to-one in-service education on 7/19/2012.regarding completing pain assessments during treatments A faculty member from Catawba Valley Community College School of Nursing who is Geriatric Certified and has a Master's Degree of Science in Nursing has been contacted to provide directed in-service education for all licensed nursing staff on Wednesday, August 8, 2012 to include Wound Management and Pain Assessments related to wounds.	8/8/12

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F 309	Continued From page 3 pain before the pain medication was given. The medication was given as follows: 7/4/12 (1) tablet at 9:00 AM 7/5/12 (1) tablet at 10:30 AM 7/7/12 two (2) tablets at 8:45 AM 7/8/12 (2) tablets at 8:50 AM 7/9/12 (1) tablet at 12:00 PM 7/10/12 (2) tablets at 9:00 AM 7/11/12 (2) tablets at 9:30 AM 7/15/12 (1) tablet at 7:00 PM 7/17/12 (2) tablets at 10:10 AM 7/18/12 (2) tablets at 9:45 AM A review of the monthly Treatment Record dated 7/1/12 through 7/31/12 indicated venous stasis ulcer (R) leg, cleanse with normal saline, skin prep, mepilex and gauze. Treatment nurse to change on Wednesday 7AM - 3 PM shift. During an observation on 7/18/12 at 10:43 AM Licensed Nurse (LN) # 1 verified the treatment on the monthly treatment record and carried supplies for a dressing change into Resident #6's room and washed her hands and put on gloves. Resident #6 was sitting in her wheelchair and a large gauze dressing surrounded her (R) lower leg and extended from below her knee to the top of her ankle. LN #1 sat down on a chair facing the resident and Resident #6 stated "the back of my (R) leg is so sore." LN #1 began to remove the dressings on the resident's (R) leg and Resident #6 clenched her teeth, squinted her eyes closed, clenched her fists and shifted from side to side in her wheelchair. The dressings were loose and were not stuck to the wounds but Resident #6's (R) leg was bright red with raw, oozing skin and open sores on the front and back of her leg. A small area of greenish drainage was	F 309	3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. Wound/Skin Protocols have been updated to reflect pain assessment prior to, during and after dressing changes. These same Protocols have been added to the front of the Wound Care Nurse Treatment books for each unit. The Wound Care Nurse Treatment Record was updated on 8/2/2012 to reflect pain assessments prior to, during and after treatments. A new pain scale with the standard numerical 1 through 10 pain scale with corresponding facial expressions was added to all TARS, MARS and Wound Care Nurse Treatment Record books. Nursing staff were in-serviced on 8/3 and 8/6/2012 by Unit Nurse Managers and the Director of Nursing regarding the location of pain assessment scales. 4) Facility's plan to monitor its performance so solutions are sustained and integrated into the facility's quality assurance system. These measures will be monitored by the Treatment Nurse and Director of Nursing with oversight by the	8/8/12

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F 309	Continued From page 4 on the back of her lower (R) leg. LN#1 saturated gauze with saline and started to clean the open areas and Resident #6 grasped each wheel of her wheelchair with her hands, closed her eyes, was groaning and stated "oh, it hurts." LN#1 stated to Resident #6, "I'm trying to hurry" and continued to place four (4) large foam dressings on the front of the resident's leg, (4) large foam dressings to the back of her leg and started to wrap them with a gauze roll dressing. Resident #6 closed her eyes tightly, was breathing rapidly and stated "oh" and started groaning. LN#1 secured the dressing with tape and repositioned the resident. LN #1 then picked up her supplies and walked out to the treatment cart in the hallway. During an interview on 7/18/12 at 10:52 AM with LN #1 she explained she was assigned to do wound care because the treatment nurse was on vacation this week. She further explained this was the first time she had seen Resident #6's (R) leg and it was "one, open multiple wound." She stated she did not know and had not checked to see if Resident #6 had received pain medication prior to the dressing change but should have because "it's hurting her a good bit." She stated she heard the resident make several sounds while she changed the dressing but she was trying to get the dressing off and back on as quickly as she could and did not think to re-assess her pain. She further stated she was not aware the resident was grimacing, clenching her fists or grabbing the wheels of her wheelchair during the dressing change. LN #1 explained Resident #6's surgeon had discussed the possibility of amputation of her (R) lower leg with Resident #6 but she refused to discuss or	F 309	Administrator through the Quality Assurance process. At least six (6) Medical record audits will be conducted weekly by the Treatment Nurse and/or Director of Nursing to verify pain assessments being completed and documented as required. The Treatment Nurse and Director of Nursing will report on the measures implemented to the Quality Assurance Committee which will monitor effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner. The Quarterly Risk Management Agenda has been updated to review all residents receiving pain management to include pain assessments. Prefix Tag:328 It is the intent of this facility to ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning;	8/8/12 8/16/12

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F 309	Continued From page 5 consent to amputation. She further explained she did the dressing change according to the instructions on the treatment record which indicated to use saline and apply foam and gauze dressings. During a follow-up interview with LN #1 on 7/18/12 at 11:12 AM she stated she would go check Resident #6's MAR to see if she had pain medication that morning. She verified Resident #6 had been given two (2) Percocet 5-325 milligram tablets orally at 9:45 AM by the medication nurse. LN #1 further stated she was not aware of this until now because she had not checked the MAR or talked with the medication nurse. During an interview on 7/18/12 at 1:55 PM Resident #6 stated her (R) lower leg was very sore because it was all open skin. She stated the slightest touch was painful and the dressing changes were very painful. During an interview on 7/18/12 at 2:00 PM the Nurse Manager explained documentation of pain was on the MAR under the "Nurse's Medication Notes" She stated the treatment nurse should talk with the medication nurse to ask about the resident's pain medication before starting a dressing change. During an interview on 7/18/12 at 1:17 PM the Director of Nurses (DON) stated it was her expectation that wound care be done according to physician's orders. She further stated pain assessments should be done before starting a dressing change on a wound and the nurse should be aware of and reassess the resident's	F 309	Respiratory care; Foot care; and Prostheses. 1) Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice. On 7/18/2012 a grid was established in the TAR to check O2 saturations every shift. Resident #6 was titrated until O2 was d/c'd on 7/27/2012. O2 saturations continued to be checked every shift which showed stability. O2 saturations have been discontinued. The Director of Nursing completed an audit of resident #6's medical record for compliance. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: In-service education was completed for licensed nurses on 6/22/2012 regarding Respiratory Policies and Procedures, How to titrate O2, and How to chart O2 saturations. O2 saturation protocols were established with the Medical Director and Attending Physicians which state: O2 saturations will be taken for: 1.All residents prior to physician notification for condition changes.	8/6/12

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F 309	Continued From page 6 level of pain during a dressing change. She explained it was her expectation that a resident's pain level according to the pain scale should be documented on the MAR before the resident received the pain medication and again when they reassessed the resident for the effects or response of the medication.	F 309	2.Specified Physician Orders 3. One per shift for physician orders with specific parameters. 4. Residents who we are titrating per this facility's titration protocol. All O2 saturations are being documented on the MARS.	
{F 328} SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews facility staff failed to monitor oxygen saturation levels for one (1) of five (5) sampled residents who received oxygen therapy (Resident #2). The findings are: Resident #2 was admitted with diagnoses including high blood pressure, congestive heart failure and chronic obstructive lung disease. The most recent significant change Minimum	{F 328}	The Staff Development Coordinator began small group directed in-service education on 7/20/2012 for all licensed nurses which included scenarios of various needs for oxygen and O2 saturations These have continued through 8/6/2012 with all licensed nurses. This facility's Medical Director directed in-service education on O2 saturations on 7/31/2012 for all licensed nurses. The Medical Director reviewed the O2 Protocols, why we do O2 saturations, and common problems with taking O2 saturations with residents who may have anemia, arthritis or cold hands. Ear monitors have been purchased per the Medical Director's suggestion for each unit to use for residents who may be difficult to obtain a correct O2 saturation level on their finger. <u>3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur.</u>	8/6/12

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{F 328}	Continued From page 7 Data Set (MDS) dated 5/18/12 indicated no impairment in short and long term memory and no impairment in cognition for daily decision making. The MDS also indicated Resident #2 required extensive assistance by staff for personal hygiene and activities of daily living (ADL's). A review of section O of the MDS titled "Special Treatments and Programs" indicated oxygen therapy for Resident #2. A review of a care plan dated 6/20/12 indicated a problem statement that Resident #2 required continuous oxygen due to congestive heart failure. A goal statement indicated the resident's oxygen saturation level would be maintained greater than 90 percent and the approaches indicated to administer oxygen at two (2) liters per minute continuously and check oxygen saturation levels as needed. A review of the monthly physician's orders dated 7/1/12 through 7/31/12 indicated to administer oxygen at two (2) liters per minute by nasal cannula to keep oxygen saturation levels greater than or equal to 92 percent. A review of the monthly treatment record (TAR) dated 7/1/12 through 7/31/12 indicated to check oxygen saturation percentages every shift and there were large "X" marks documented on each day from 7/1/12 through 7/18/12 on the 11PM - 7AM shift. During an observation on 7/18/12 at 8:45 AM Resident #2 was lying in her bed with a nasal cannula in her nose and oxygen on at two (2) liters per minute from an oxygen concentrator. The resident's skin color was pale and she had	{F 328}	All residents receiving oxygen have physician orders profiled in the MAR. The O2 saturation protocols have been updated to guide staff. The CQI checklist for Charge Nurses was updated to address monitoring for O2 saturation levels. 4) Facility's plan to monitor its performance so solutions are sustained and integrated into the facility's quality assurance system. These measures will be monitored by the Director of Nursing with oversight by the Administrator through the Quality Assurance process. The Director of Nursing and/or the Assistant Director of Nursing will audit all medical records of residents receiving oxygen on a weekly basis. The Director of Nursing will report on the measures implemented to the Quality Assurance Committee which will monitor effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner. The Quarterly Risk Management Agenda has been updated to review all residents receiving oxygen including O2 saturations.	8/6/12

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{F 328}	Continued From page 8 some mild shortness of breath when she spoke. During an interview on 7/18/12 at 8:47 AM Resident #2 stated she wore her oxygen all of the time and it helped her but sometimes she felt like she was "smothering" and felt out of breath. She further stated she was not sure if the nurses checked her oxygen levels. During an interview on 7/18/12 at 2:36 PM Licensed Nurse (LN) #2 stated sometimes nurses documented oxygen saturation levels on the medication administration record (MAR) and sometimes on the treatment record (TAR). She stated she was the medication nurse for the hall that day and she had not checked Resident #2's oxygen saturation levels until this morning. She verified the large "X" marks on the TAR indicated Resident #2's oxygen saturation percentages had not been checked from 7/1/12 through 7/18/12 on the 11 PM - 7AM shift and the large "X" meant they had not been checked. She stated she was not sure why they had not been done, but they must have been overlooked on the TAR. During an interview on 7/18/12 at 2:48 PM the Director of Nurses (DON) stated she discovered the oxygen saturation percentages had not been checked on each shift for Resident #2 until this morning. She further stated it was her expectation for physician's orders to be followed and the oxygen saturation percentages should have been documented for each shift on the TAR for Resident #2.	{F 328}		8/6/12