| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| LENOIR HEALTHCARE CENTER | 322 NUWAY CIRCLE LENOIR, NC 28645 |

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| F 157 SS=D | 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br><br>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).<br><br>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.<br><br>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, physician interview and staff interviews, the facility failed to notify the | F 157 | ***F 157 SS=D***<br>***This plan of correction is the facilities credible allegation of compliance.***<br>• Resident number three is no longer a resident in this facility.<br>• Audit of current residents with change in condition was conducted by DON to assure Physicians were notified and documented in medical record. on 10/16/2012.<br>• Beginning 10/16/2012 Nurses re-educated prior to working next shift on indentifying changes in condition and proper follow-up with Physicians and documented in medical record. (ADON/Designee).<br>•Twenty-four hour report is being audited for indicators of changes in condition and proper notifications and documentation in medical record. three times weekly for four weeks, then weekly times three months.(DON/Designee)<br>• The Director of Nursing will prepare a summary of monitoring for presentation during the monthly QA Committee Meeting times three months where the success of the plan will be reported and decisions to change it when necessary will be discussed.<br>***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepare and/or executed solely because it is required by provisions of state and federal law.*** | 11/06/12 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Greene — TITLE: LNHA — (X6) DATE: 11/09/2012

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.

Original Signature Date: 11-6-12

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| F 157 | Continued From page 1 | F 157 | | |

physician when 1 of 4 sampled residents had a change in condition. (Resident #3).

The findings are:

The facility's policy "Change in Resident Medical Status/Condition" dated 06/11 included "All staff will communicate any information about patient status changes to the appropriate licensed personnel immediately upon observation."

Resident #3 was admitted to the facility in 2009 and recently readmitted following a hospitalization on 10/10/12 following a fractured hip. His diagnoses included aspiration pneumonia, esophageal reflux, and gastrointestinal bleeding.

Physician progress notes dated 06/20/12 noted a recent hospitalization and recurrent nausea and vomiting with testing showing gastritis, evidence of gastrointestinal bleeding and anemia requiring transfusion. Physician progress notes dated 09/21/12 noted recurrent vomiting with etiology escaping detection. Physician progress notes dated 10/03/12 noted an acute visit following a fall with fractured hip requiring hospitalization and surgery. Physician progress notes dated 10/10/12 revealed recurrent nausea and vomiting resulting in decreased intake and weight loss. The note indicated the etiology escaped detection.

Review of the nursing notes revealed no documentation of nausea or vomiting from readmission on 10/10/12 until a therapist note dated 10/13/12 at 11:35 AM. This note stated when the therapist arrived to provide therapy, the resident had vomited black coffee ground emesis

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| F 157 | Continued From page 2 | F 157 | | |

over himself, the chair, both sides of the floor and the wall. The therapist noted that during bed mobility, Resident #3 coughed up black coffee grounds into a kleenex which she showed the nurse on duty.

Nursing notes dated 10/13/12 at 2:09 PM revealed Resident #3 continued to have vomiting episodes and that the housekeeping staff and nurse aides had to clean the room and the resident several times throughout the morning. Nursing notes dated 10/13/12 at 6:01 PM noted the resident continued to have dark brownish emesis.

A nursing note dated 10/13/12 at 11:31 PM stated that at 7:30 PM family reported concern relating to more emesis and the nurse indicated to the family that this information was placed on the physician's round sheet (an ongoing list of concerns for the physician to review during his daily rounds).

A telephone interview was conducted with Nurse #3 on 10/19/12 at 4:40 AM. Nurse #3 confirmed that she worked with Resident #3 on 10/12/12-10/13/12 during the 11:00 PM - 7:00 AM shift. Nurse #3 stated Resident #3 vomited twice during the night shift. She stated she relayed this information to the oncoming nurse at shift change, Nurse #1. She further stated she did not report this to the day charge nurse, Nurse #4.

Interview with Nurse #1 on 10/18/12 at 2:06 PM revealed he had received report from night shift that Resident #3 had been given a suppository for his nausea and vomiting. Nurse #1 stated Resident #3 had emesis on and off all day on

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| F 157 | Continued From page 3<br>10/13/12. He stated this was usual, except that Resident #3 had more emesis than usual. Nurse #1 stated Resident #3 needed to be cleaned three to four times before lunch was served due to vomiting. Nurse #1 stated he did not see Resident #3's physician this date. Nurse #1 stated during a follow up interview on 10/18/12 at 2:28 PM that he thought he had told Nurse #4 about the numerous vomiting episodes Resident #3 was having but he did not until after the family arrived and voiced concern. He stated Nurse #4 would have been responsible for physician notification.<br><br>An interview was conducted with the charge nurse, Nurse #4 on 10/18/12 at 2:30 PM. Nurse #4 stated he was the charge nurse during first shift on 10/13/12. Nurse #4 stated he received report when he started his shift from the third shift and from the 24 hour written reports. Nurse #4 stated it was reported to him that Resident #3 was nauseated but nothing about vomiting. Nurse #4 stated he was unaware that Resident #3 had numerous vomiting episodes until family arrived and voiced concern. Nurse #4 stated, if he had known he would have reported to the physician. Once the family expressed concern, Nurse #4 stated he called the Director of Nursing (DON) for direction who relayed Resident #3's physician was aware of his nausea and vomiting. Nurse #4 stated he documented Resident #3's condition on the 24 hour report and on the physician's round sheet. Nurse #4 relayed Resident #3's condition to the oncoming second shift nurse, Nurse #2.<br><br>Review of the 24 hour shift reports for 10/12/12 revealed no documentation of Resident #3's | F 157 | | |

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| F 157 | Continued From page 4 | F 157 | | |

condition. There was a notation that phenergan suppository was administered on 10/13/12 at 2:30 PM, but no other information relating to his condition.

The DON stated on 10/18/12 at 3:10 PM there was no physician round sheet found for Resident #3's physician for 10/12/12. Review of the physician's round sheet for 10/13/12 revealed nothing about Resident #3 from day shift.

Interview with Nurse #2 on 10/18/12 at 3:35 PM revealed she worked with Resident #3 on 10/13/12 during second shift. It was reported to her Resident #3 had vomiting. During the shift, family expressed concern about Resident #3. Nurse #2 stated she did not call the physician but did put a note on the physician's round sheet. Review of the physician's round sheet dated 10/13/12 revealed the only notation regarding Resident #3 was from Nurse #2 that the resident continued to have dark brown emesis and family expressed concern about this issue.

On 10/18/12 at 12:15 PM, Resident #3's physician (MD) was interviewed. The MD stated he came to the facility daily and staff reported any issues to him verbally and via the physician's round sheet. He stated he was in the facility on 10/12/12 and 10/13/12 and was not informed of Resident #3' vomiting. He stated he was unaware of any concerns relating to Resident #3 until 10/14/12. During follow up interview with MD on 10/19/12 at 10:11 AM, the MD stated he would have expected to be informed of Resident #3's vomiting.

Interview with the DON on 10/19/12 at 10:39 AM

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| F 157 | Continued From page 5<br>revealed Resident #3's continued vomiting should have been written on the 24 hour sheets to alert the oncoming shifts. She further stated she was aware of his vomiting but not to the extent of him having projectile vomiting. She stated that since he had a history of vomiting, she did not feel it was necessary to inform the physician. | F 157 | ***F 514 SS=D***<br>***This plan of correction is the facilities credible allegation of compliance.***<br><br>• Resident number three is no longer a resident of this facility. | 11/06/12 |
| F 514 SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to document nursing assessments completed during a change in condition for 1 of 4 sampled residents. (Resident #3).<br><br>The findings are:<br><br>The facility's policy "Change in Resident Medical Status/Condition" dated 06/11 included "All staff will communicate any information about patient status changes to the appropriate licensed | F 514 | • Audit of current residents with acute episodes was conducted by DON to assure proper documentation in medical record on 10/16/12.<br>• Beginning 10/16/2012 Nurses re-educated prior to working next shift on proper documentation of nursing assessment in nurses notes in permanent medical record completed during a change in condition. (ADON-Designee)<br>• Audit of twenty-four hour report for accuracy of documentation in nurses notes in permanent record is being checked three times weekly for four weeks, then weekly times three months.(DON/Designee)<br>• The Director of Nursing will prepare a summary of monitoring for presentation during the monthly QA Committee Meeting times three months where the success of the plan will be reported and decisions to change it when necessary will be discussed.<br><br>***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepare and/or executed solely because it is required by provisions of state and federal law.*** | |

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| F 514 | Continued From page 6 | F 514 | | |

personnel immediately upon observation." The policy also included the procedure "Change in medical status will be documented on the 24-hour report."

Resident #3 was admitted to the facility in 2009 and recently readmitted following a hospitalization on 10/10/12 for a fractured hip. His diagnoses included aspiration pneumonia, esophageal reflux, and gastrointestinal bleeding and a history of nausea and vomiting.

Review of the nursing notes revealed no documentation of nausea or vomiting from readmission on 10/10/12 until a therapist note dated 10/13/12 at 11:35 AM. This note stated when the therapist arrived to provide therapy, the resident had vomited black coffee ground emesis over himself, the chair, both sides of the floor and the wall. The therapist noted that during bed mobility, Resident #3 coughed up black coffee grounds into a kleenex which she showed the nurse on duty.

Nursing notes dated 10/13/12 at 2:09 PM revealed Resident #3 continued to have vomiting episodes and that the housekeeping staff and nurse aides had to clean the room and the resident several times throughout the morning. Nursing notes dated 10/13/12 at 6:01 PM noted the resident continued to have dark brownish emesis.

A nursing note dated 10/13/12 at 11:31 PM stated that at 7:30 PM family reported concern relating to more emesis and the nurse indicated to the family that this information was placed on the physician's round sheet (an ongoing list of

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| F 514 | Continued From page 7<br>concerns for the physician to review during his daily rounds).<br><br>A telephone interview was conducted with Nurse #3 on 10/19/12 at 4:40 AM. Nurse #3 confirmed that she worked with Resident #3 on 10/12/12-10/13/12 during the 11:00 PM - 7:00 AM shift. Nurse #3 stated Resident #3 vomited twice during the night shift and she administered a phenergan suppository. She stated she relayed this information to the oncoming nurse at shift change, Nurse #1. She further stated she did not report this to the day charge nurse, Nurse #4. Review of the 24 report for this shift revealed no documentation of the vomiting or suppository. Review of the Medication Administration Record (MAR) for this shift revealed nothing indicating the administration of the suppository.<br><br>Interview with Nurse #1 on 10/18/12 at 2:06 PM revealed he had received report from night shift that Resident #3 had been given a suppository for his nausea and vomiting. Nurse #1 stated Resident #3 had emesis on and off all day on 10/13/12. He stated this was usual, except that Resident #3 had more emesis than usual that date. Nurse #1 stated Resident #3 needed to be cleaned three to four times before lunch was served due to vomiting. Nurse #1 stated he thought he consulted with the charge nurse, Nurse #4, was responsible for calling the physician. Nurse #1 further stated he administered a phenergan suppository in the afternoon. He related he waited because Nurse #3 had informed him she had given Resident #3 one on her shift but had not documented it. Because he did not know when Nurse #3 administered the suppository, he waiting the | F 514 | | |

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allotted time (at least 6 hours) to administer another one. During follow up interview on 10/19/12 at 2:02 PM, Nurse #1 stated he checked on Resident #3 several times during the morning of his shift on 10/13/12 and knew staff obtained vital signs on him later in the day. He recalled they were within normal limits. He stated that his assessments would have included review of vital signs, the resident's mental status, color, etc. Review of the nursing notes written by Nurse #1 on 10/13/12 revealed no documented assessment of Resident #3's physical, other than vomiting black coffee ground emesis, or mental condition. The 24 hour sheet only noted the administration of phenergan at 2:30 PM by Nurse #1.

An interview was conducted with the charge nurse, Nurse #4 on 10/18/12 at 2:30 PM. Nurse #4 stated he was the charge nurse during first shift on 10/13/12. Nurse #4 stated he received report when he started his shift from the third shift and from the 24 hour written reports. Nurse #4 stated it was reported to him that Resident #3 was nauseated but nothing about emesis. Nurse #4 stated he was unaware that Resident #3 had numerous vomiting episodes until family arrived and voiced concern. During follow up interview on 10/19/12 at 12:09 PM, Nurse #4 stated Nurse #1 told him Resident #3's vital signs were stable and that he assessed Resident #3 himself but failed to document any of his assessment. Nurse #4 stated he documented Resident #3's condition on the 24 hour report and on the physician's round sheet. Nurse #4 relayed Resident #3's condition to the oncoming second shift nurse, Nurse #2. Review of the 24 hour sheet revealed nothing from Nurse #4 about Resident #3.

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| F 514 | Continued From page 9<br><br>The DON stated on 10/18/12 at 3:10 PM there was no physician round sheet found for Resident #3's physician for 10/12/12. Review of the physician's round sheet for 10/13/12 revealed nothing about Resident #3 from day shift.<br><br>Interview with Nurse #2 on 10/18/12 at 3:35 PM revealed she worked with Resident #3 on 10/13/12 during second shift. It was reported to her Resident #3 had vomiting. During the shift, family expressed concern about Resident #3. Nurse #2's nursing notes documented the administration of pain medication and oxygen saturation percentage but no vital signs or physical assessment of Resident #3 until 8:50 PM. Nurse #2 stated she did not call the physician but did put a note on the physician's round sheet. Review of the physician's round sheet dated 10/13/12 revealed the only notation regarding Resident #3 was from Nurse #2 that the resident continued to have dark brown emesis and family expressed concern about this issue. Nurse #2 stated she checked on Resident #3 and noted no change but noted him getting weaker and her deciding to send him to the emergency room at approximately 8:30 PM. There was no documentation of any assessment or indication relating to the decision to send him to the emergency room.<br><br>Interview with the Director of Nursing (DON) on 10/19/12 at 10:39 AM revealed Nurse #1 should have documented Resident #3's vomiting on the 24 hour sheet and documented the administration of phenergan. The DON stated vital signs should have been taken and documented every shift. She further stated the nurses should have | F 514 | | |

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| F 514 | Continued From page 10<br>documented Resident #3's condition in more detail regarding their nursing assessments on the resident.<br><br>Review of the vital sign documentation revealed the only vital signs documented for 10/13/12 included:<br>*3:33 PM: oxygen saturation on 2 liters of oxygen at 94%; and<br>*4:41 PM: blood pressure 120/70, axillary temperature 98.3, pulse 74, respirations 18. | F 514 | | |