STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345281	A. BUILDING: _____ B. WING _____	3/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH RD BOX 38 ALBEMARLE, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 157	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 record review and staff interviews, the facility failed to notify the legal representative for 1 of 3 sampled residents (Resident #2) who had a significant change.

The findings included:

Resident #2 was admitted to the facility on 7/20/11 and then re-admitted on 10/26/11. Her cumulative diagnoses included: mood disorder, paranoid hallucinations and anxiety. On her annual Minimum Data Set (MDS) assessment, dated 11/28/12, she was determined to have moderate cognitive impairments and exhibited behavioral symptoms, not directed at others.

A chart review was conducted and revealed that Resident #2 was referred in December, 2012 for psychiatric services after she exhibited an increase in depression, hallucinations and anxiety. She was treated with Seroquel, an anti-psychotic medication but on 1/7/13, her therapist recommended adding Ativan, an anti-anxiety to her drug regimen.

On 1/7/13 at 10:40 pm, Nurse #1 recorded in her notes that there was a new order to increase the Seroquel to 50 milligrams twice a day and added Ativan 0.25 milligram twice a day. She then wrote, "RP (responsible party) to be notified".

Nurse #1 was interviewed on 3/12/13 at 3:26 pm. She mentioned that Resident #2 became more guarded and paranoid and an effort was made to relieve her anxiety. She commented that she spoke to the doctor when the

The above isolated deficiencies pose no actual harm to the residents

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new order was written and always contacted the RP to discuss new changes. However, she shared that when new orders were written after 10:00 pm for non-urgent matters, it was a general practice at the facility to wait until the next business day to contact the RP. She stated that was the reason that she recorded that the "RP should be notified".

Nurse #1 shared that whenever, the next shift nurse must follow up on something that the previous nurse started, she would mark the shift report to indicate this, as well as share those instructions during her verbal shift report.

The nurse's notes on 1/8/13 reflect that a family member was visiting Resident #2 at 9:45 am, when Nurse #2 was approached about a change in her condition. Nurse #2 recorded that she assessed Resident #2 for slurred speech and muscle weakness, but she did not discuss the addition of Ativan to her drug regimen, to treat her anxiety.

The Director of Nursing was interviewed on 3/12/13 at 5:10 pm. She commented that she had reviewed Resident #2's chart and could not find any documentation in her file, or in the shift report that either nurse contacted the RP to notify the representative about the changes made to her medication. She stated that she contacted Nurse #2 by telephone and the nurse relayed that she could not recall discussing the Ativan with the family member, on 1/8/13.

The Director of Nursing shared that if a non-urgent change in condition occurred after 10:00 pm with a resident, then the nurse was expected to wait until the following day to contact the RP.

F 205 483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR

Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.

At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to communicate a written Bed Hold Policy at the time of admission and/or hospital discharge for 1 of 3 sampled residents (Resident #2).

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The findings included:

A copy of the facility's Resident Handbook, was reviewed. It read, " Bed Hold Policy: I acknowledge that I have received the facility's bed hold policy. I understand that Medicare/Medicaid will not pay for holding a bed during hospitalization and I am responsible for notification and payment to the facility if a bed is to be held. I further understand that when a bed is not held, the facility cannot guarantee placement when discharged but the resident is assured of the next available appropriate bed for readmission."

Resident #2 was admitted to the facility on 7/20/11 and then re-admitted on 10/26/11. Her cumulative diagnoses included: mood disorder, chronic kidney disease and pulmonary embolism. On her annual Minimum Data Set (MDS) assessment, dated 11/28/12, she was determined to have moderate cognitive impairments.

A chart review was conducted from her admission and business records. It revealed that Resident #2 was originally discharged home on 10/21/11, but returned to the facility as a new admission on 10/26/11.

In her business file was a Financial Agreement, dated 7/20/11 by one of her responsible party (RP) members. Under the Bed Hold Policy, there was no checked box to indicate if the RP wanted to secure a bed in the event of a temporary absence or release it.

On 3/12/13 at 11:40 am, the Business Office Manager was interviewed. She stated she was not sure why Resident #2 chart lacked a signed admission packet when she was re-admitted on 10/26/11. She explained that normally the Admission's Coordinator contacts the RP on the day of a hospital transfer, instead of giving written notification. On 1/28/13, she recalled speaking to the spouse of the RP who indicated that they would call the facility back with their decision about the bed hold.

On 3/12/13 at 2:06 pm, the Admission's Coordinator was interviewed. She shared that she initiated a phone call to the RP around 9:00 am on 1/28/13, when she learned that Resident #2 was admitted to the hospital. She recalled discussing their nightly rate and told him that a payment, totaling three days would be required up front to hold Resident #2's bed. She shared with the RP that he needed to give her a decision by noon, the same day in order to hold the bed.

The Admission Coordinator acknowledged that the conversation between the RP and herself, involved him becoming angry at her and yelling. When the RP didn't contact her before noon, she released the bed, and offered it to another resident from the rehabilitation hall who intended to be a long term resident.

She stressed that it was not her practice to mail the bed hold policy at the time of a hospitalization, because she needed to know the same day if the RP intended to pay or release the bed. She shared that all families are given an Resident Handbook at the time of the admission which discussed the bed hold policy.

The Admission Coordinator commented that she does not record notes when she discussed bed holds with a RP. However, she recalled that the RP for Resident #2 chose to waive signing a new admissions packet when

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she returned to the facility on 10/26/11.

On 3/12/13 at 2:30 pm, the Director of Nursing (DON) was interviewed. She stated that the nursing staff does not discuss the bed hold policy with the RP when a hospital transfer took place, nor do they send a bed hold policy with the ambulance staff, to accompany the resident. She shared that it was their procedure to have the Admission Coordinator call the family afterwards to explain the bed hold.

The Administrator was interviewed on 3/12/13 at 4:45 pm. She shared that she met with the responsible party members, the afternoon of 1/28/13 to discuss their bed hold policy. One of the RP's explained to her that he had difficulty making a return call to them during his work day but intended to hold the bed for Resident #2. However, when they arrived, they noticed that Resident 2's room was packed up and an internal transfer had already been made. At that point, she shared that the family of Resident #2 made the decision to release her bed.

The Administrator stated that she explained to the RP that at the time Resident #2 was ready to be discharged from the hospital that she could be re-admitted to the facility if a bed was still available. She also shared that when a hospital transfer occurred over the weekend that the facility would wait until the next business day to contact the family to discuss their bed hold policy, but in the event of Resident #2, her transfer was during the week and they only hold the bed until noon.