

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345385	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/31/2013
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NAME OF PROVIDER OR SUPPLIER CARDINAL HEALTHCARE AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 931 N ASPEN ST LINCOLN, NC 28092
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(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	F 000		
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interviews the facility failed to treat 1 of 2 sampled residents, who has visual impairment, with dignity and respect by staff not identifying themselves before providing care (Resident #61).</p> <p>The findings included:</p> <p>Resident #61 was admitted to the facility on 05/09/13 with diagnoses including hypertension, renal insufficiency, diabetes mellitus and has a requirement for dialysis.</p> <p>The initial Minimum Data Set (MDS) dated 05/17/13 indicated Resident #61 was cognitively intact. The MDS further indicated he had severe impaired vision, seeing only light and colors or shapes. Resident #61 was assessed for most activities of daily living (ADL) as requiring extensive assistance with 1 to 2 person assist.</p> <p>A review of Resident #61's care plan dated 05/17/13 included a problem that Resident #61 was legally blind. One approach directed staff to</p>	F 241	<p>F 241 Dignity and Respect</p> <ol style="list-style-type: none"> 1. Resident #61 suffered no harm. 2. This has the potential to affect visually impaired resident in the facility. The Facility Director of Clinical Services (DCS) and Minimum Data Set (MDS) Director reviewed current residents to identify those who are visually impaired. Facility DCS/Nurse Manager re-educated current facility staff to announce themselves upon entering residents' rooms and/or before providing care for those residents who are visually impaired. 3. Facility DCS/Facility Social Service Director (SSD) will conduct Quality Improvement (QI) monitoring to ensure staff are announcing themselves upon entering residents' rooms and/or before providing care for those residents who are visually impaired. QI monitoring will be conducted 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months, using a sample of 5. 	6/28/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Adel G. [Signature]* TITLE: EXECUTIVE DIRECTOR (X6) DATE: 6/28/13

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: 6-24-13



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F 241	<p>Continued From page 1</p> <p>announce their name as they entered the Resident's room.</p> <p>An interview was conducted on 05/28/13 at 3:17 PM with Resident #61. He stated he had reported an incident to a third shift Nurse Aide (NA) and he had not known her name because she had not identified herself.</p> <p>An interview was conducted on 05/31/13 at 5:19 AM with NA #1. She stated Resident #61 was very visually impaired but she thought he had known the NAs by their voice. She stated she had not introduced herself when she had provided care to Resident #61.</p> <p>An interview was conducted on 05/31/13 at 5:29 AM with NA #2. She stated she had not introduced herself when she had provided care to Resident #61 because she had thought the resident had recognized staff voices.</p> <p>A follow up interview was conducted with Resident #61 on 05/31/13 at 1:52 PM. He stated staff have not announced themselves and he had not always known staff by their voices. He said when staff came into his room without announcing themselves and placed their hands on his shoulder it scared him.</p> <p>An interview was conducted on 05/31/13 at 2:04 PM with Nurse #6. She stated when she worked at the facility as an NA she announced herself to Resident #61. She reported when she became a Nurse at the facility she quit announcing herself because she had thought the resident had recognized her voice.</p>	F 241	<p>4. Facility SSD will report results of QI monitoring to the Quality Assurance/Performance Improvement (QA/PI) Committee monthly x 12 months for continued substantial compliance and/or revision.</p>		

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F 241	Continued From page 2 An interview was conducted on 05/31/13 at 3:28 PM with the Director of Nursing. She stated she had thought Resident #61 recognized staff by their voices. She said she had not been aware Resident #61 had a specific care plan approach directing staff to announce themselves before providing care to him. She revealed her expectation was staff should announce themselves and inform Resident #61 of what care they were going to provide.	F 241			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F 329 Drug Regimen 1. Resident #105 suffered no harm. Resident #105's nurse notified the physician regarding the missed valproic acid level; and new orders were given, received and implemented to obtain Resident #105's valproic acid level on 5/30/13. Resident #105's valproic acid level results were received on 5/30/13 and were within normal limits. Resident #105's nurse notified the physician of the results on 5/30/13 and no new orders were given. At this time, Resident #105 no longer resides in the facility. 2. Licensed Nurses were in-serviced by the DCS and Nurse Manager on with regard to processing lab orders to include logging lab orders in the lab book on the scheduled due date, completion of the labs as ordered	6/28/13	

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F 329	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to follow physician orders and failed to notify a physician or nurse practitioner that a valproic acid (VA) level was not drawn for 1of 10 residents reviewed for unnecessary medications (Resident #105). The findings included: Resident #105 was admitted to the facility on 05/08/13 with diagnoses including cerebral vascular accident, hypertension, coronary artery disease and epileptic seizure disorder. Review of a hospital discharge summary dated 05/08/13 indicated Resident #105 had blood drawn during hospital services and a VA level was undetected. The summary further indicated Resident #105 was started on the anti-seizure medication depakote during hospital stay and would need a VA level checked as an outpatient. A review of Resident #105's medical record revealed physician orders dated 05/09/13. The orders specified administer depakote 500 milligrams (mg) by mouth twice daily and draw a VA level on 05/16/13. A review of the Medication Administration Record (MAR) for 05/08/13 through 05/31/13 revealed Resident #105 received the medication depakote per physician orders. The Minimum Data Set (MDS) dated 05/17/13 indicated Resident #105 had no problems with	F 329	and notification to the physician of lab results. A second check system was put in place to include the review of new lab orders in Morning Interdisciplinary Team Meeting on Monday through Friday by the DCS/Nurse Manager. DCS/Nurse Manager will then verify that the orders were properly logged on the scheduled due date, completed as ordered and the physician was notified of the results. 3. Facility DCS/Nurse Manager will conduct QI monitoring of residents' labs to ensure that the labs were drawn per the physician's order. QI monitoring will be conducted 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months, using a sample size of 5. 4. Facility DCS/Nurse Manager will report results of QI monitoring to the QA/PI Committee monthly x 12 months for continued substantial compliance and/or revision.	

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F 329	Continued From page 4 short term and long term memory and the resident was cognitively intact. During an interview on 05/30/13 at 3:00 PM Nurse #1 stated lab work for residents was entered into an electronic lab computer system and a lab slip was generated which reflected the date and blood level to be drawn by the lab technician. She further stated the resident room number and lab information was written on the desk calendar as a backup reminder and the calendar was checked daily by unit managers. Nurse #1 stated she was unaware Resident #105 needed a blood draw on 05/16/13 and indicated no information was written for the date 05/16/13 on the calendar. During an interview on 05/30/13 at 3:55 PM Nurse #2 stated when a physician orders blood work a lab slip requisition should be faxed to the lab technician. She further stated she was aware of a physician order for a VA level on 05/16/13 for Resident #105 but was unaware the blood level was not drawn. During a telephone interview on 05/30/13 at 4:10 PM the Nurse Practitioner stated her expectation was she or the physician would be informed if blood was not drawn on a resident. She stated when an anti-seizure medication was started such as depakote a VA level would be drawn within a couple of weeks. She further stated she was unaware the VA level had not been drawn on Resident #105.	F 329			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of	F 332			

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F 332	<p>Continued From page 5</p> <p>medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility medication error rate was greater than 5%, as evidenced by 2 medication errors out of 25 opportunities, resulting in a medication error rate of 8% observed for 2 of 7 residents observed during medication pass (Residents #45 and #71).</p> <p>The findings included:</p> <p>1. Resident #45 was admitted to the facility 08/01/12 with diagnoses including history of stroke and left eye conjunctivitis.</p> <p>A review of Resident #45's medical record revealed a physician's order dated 10/10/12 for artificial tears one drop to each eye four times a day.</p> <p>On 05/29/13 an observation at 3:19 PM revealed Nurse #5 administered 2 drops of artificial tears to each eye.</p> <p>An interview with Nurse #5 on 05/30/13 at 3:24 PM revealed Resident #45 asked for the additional drop of artificial tears. She stated this was an occasional request from this resident to promote comfort. Nurse #5 stated she had not informed the physician of the resident's need.</p> <p>An interview with the Director of Nursing on 05/31/13 at 2:25 PM revealed it was her</p>	F 332	<p>F 332 Free of Medication Error</p> <ol style="list-style-type: none"> Residents #45 and #71 suffered no harm. This has the potential to affect facility residents with physician's orders, to include medication administration as well as residents receiving medications via Gastric Tube. Facility DCS/Nurse Manager re-educated current licensed nurses on the facility's policies and procedures for medication administration to include but not be limited to administration of meds per Gastric Tube with return demonstration by current licensed nurses. Staff were in-serviced that there should be no cocktailing of meds per Gastric Tubes. Licensed Nurses were educated that each medication is administered separately via tube, each followed by 10 – 15cc of water. Staff were also in-serviced in following physicians' orders and administration of eye drops. Staff were in-serviced that eye medications in drop form must be administered per the number of drops ordered by the physician. The technique of instilling the eye 	6/28/13	

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F 332	<p>Continued From page 6</p> <p>expectation for doctor's orders to be followed for medication administration.</p> <p>2. Resident #71 was admitted to the facility 04/07/11 with diagnoses including Barrett's esophagus, aspiration pneumonia and gastrostomy tube (GT) placement.</p> <p>A review of Resident #71's physician monthly orders for 05/01/13 through 05/31/13 revealed instructions to administer the following medications via GT daily at 8:00 AM: celexa 10 milligrams (mg), multi vitamin 5 milliliters (ml), lisinopril 10 mg, prilosec 20 mg sprinkle, metformin 250 mg, colace 100 mg, and loproressor 25 mg.</p> <p>An observation was conducted on 05/30/13 at 8:25 AM of Nurse #6 administering medication to Resident #71 via GT. All of the 8:00 AM medications were crushed or sprinkled, mixed with the 1 liquid medication and added to water. Nurse #6 administered the mixed solution with intermittent flushes of water.</p> <p>An interview with Nurse #6 on 05/30/13 at 8:41 AM revealed her usual practice was to mix all the medications together, sprinkle the prilosec then mix all with the multi vitamin liquid and add water. She added she had not been trained to administer GT medications differently.</p> <p>An interview with the Director of Nursing (DON) on 05/31/13 at 2:25 PM revealed she was unaware Resident #71 did not have a physician's order to mix the medications together when they were administered via GT. She stated when no physician's order instructed differently, she</p>	F 332	<p>drops were also reviewed to ensure staff were aware to ensure careful administration to ensure that the physicians order was being followed. Completed on 6/13/13.</p> <p>3. Facility DCS/Nurse Manager will conduct QI monitoring of medication administration to include but not be limited to following physicians' orders for eye drop administration and Gastric Tube medication administration by facility licensed nurses to ensure administration is per facility policies and procedures. QI monitoring will be conducted on 5 residents with gastric tube medications and 5 residents with eye drop administration weekly for 4 weeks, then 3 residents with gastric tube medications and 3 residents with eye drop administration weekly for 4 weeks, then 1 resident with gastric tube medications and 1 resident with eye drop administration weekly for 4 weeks, and then 1 resident with gastric tube medications and 1 resident with eye drop administration monthly for 9 months, using a sample size of 3 nurses to encompass a licensed</p>		

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F 332	Continued From page 7 expected medications were to be administered via GT individually utilizing water flushes between each medication.	F 332	nurse on each shift. Facility licensed nurses noted to use improper technique with medication administration will receive immediate re-education by the facility DCS/Nurse Manager. 4. Facility DCS/Nurse Manager will report results of QI monitoring to the QA/PI Committee monthly x 12 months for continued substantial compliance and/or revision.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441		

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F 441	<p>Continued From page 8</p> <p>transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to clean a saline cleansing solution container utilized on a dressing change before replacing it back into the treatment cart for reuse for 1 of 2 observed dressing changes.</p> <p>The findings included:</p> <p>Resident #75 was admitted to the facility on 01/18/13. Current diagnoses included a recurrent pressure ulcer on the right heal.</p> <p>On 05/30/13 at 2:23 PM an observation was conducted of Nurse #6 changing Resident #75's dressing on the right heal. When Nurse #6 set up the supplies utilized for the dressing change, she placed a saline cleansing solution container directly on the resident's over bed table. Using gloved hands, Nurse #6 held the resident's leg in an upward position and placed the saline cleansing solution container under the resident's wound. The nozzle of the container was observed directly under the resident's open wound as the cleanser was sprayed into the wound allowing overspray to fall onto the nozzle. Nurse #6 then replaced the container directly onto the over bed table. When the dressing change was complete, Nurse #6 was observed containing the soiled dressings in a bag and washing her hands. She picked up the saline cleansing solution container and approached the treatment</p>	F 441	<p>F 441 Infection Control:</p> <ol style="list-style-type: none"> 1. Resident #75 suffered no harm. Resident #75 was seen by the physician on 5/31/13 and no new orders were given. 2. This has the potential to affect facility residents receiving dressing changes in the facility. The Facility DCS/Nurse Manager reviewed current residents to identify any having a dressing change to further ensure that they were clinically stable. Facility DCS/Nurse Manager re-educated current facility licensed nurses on facility's policy and procedure for infection control with regard to wound dressing changes completed on 5/29/13. All Licensed Nurses were re-educated to clean any re-usable items with bleach wipes prior to returning items to the treatment cart. In addition, the spray bottles of wound cleanser were replaced with single use packages. 3. Facility DCS/Nurse Manager will conduct QI monitoring to ensure nurses are using proper infection control practices during dressing changes. QI monitoring will be conducted on 5 residents with 	6/28/13	

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F 441	Continued From page 9 cart with the intention of replacing it into the treatment cart supplies utilized for all residents. In an interview immediately following the dressing change, Nurse #6 stated she was unaware of the need to clean the saline cleansing solution container before replacing it into the cart. Nurse #6 was observed obtaining information from a supervisor regarding cleaning of equipment before returning it to the treatment cart for reuse. An interview was conducted with the Director of Nursing on 05/31/12 at 2:25 PM. She stated the saline cleansing solution container should have been cleaned after each use before replacing it in the treatment cart.	F 441	wounds weekly for 4 weeks, then 3 residents with wounds weekly for 4 weeks, then 1 resident with wounds weekly for 4 weeks, and then 1 resident with wounds monthly for 9 months, using a sample size of 2 nurses across different shifts. Facility licensed nurses noted to use improper technique with regard to infection control during wound dressing changes will receive immediate re-education by the facility DCS/Nurse Manager. 4. Facility DCS/Nurse Manager will report results of QI monitoring to the QA/PI Committee monthly x 12 months for continued substantial compliance and/or revision.		