

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:  345229	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/23/2013
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NAME OF PROVIDER OR SUPPLIER  PEAK RESOURCES - SHELBY	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 SHELBY, NC 28150
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F 000	<p>INITIAL COMMENTS</p> <p>The statement of deficiencies was amended on 06/14/13 following the Informal Dispute Resolution results notice from the Centers for Medicare and Medicaid Services. The period of immediate jeopardy was changed in tags F 242, 309 and 323 and the order of the examples was reversed. The scope and severity for tag F 520 was reduced from a "J" to a "D".</p> <p>483.15 (F242) at J Immediate Jeopardy began on 12/27/12 at 8:00 PM when facility staff did not honor Resident #114's choice for Do Not Resuscitate (DNR) when the resident stopped breathing and cardiopulmonary resuscitation (CPR) was started. The Administrator was informed of Immediate Jeopardy on 03/20/13 at 2:37 PM. Immediate Jeopardy was removed on 03/23/13 at 6:10 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and to ensure monitoring systems put into place are effective.</p> <p>483.25 (F309) at J Immediate Jeopardy began on 12/27/12 at 8:00 PM when facility staff did not honor Resident #114's choice for Do Not Resuscitate (DNR) when the resident stopped breathing and cardiopulmonary resuscitation (CPR) was started. The Administrator was informed of Immediate Jeopardy on 03/20/13 at 2:37 PM. Immediate Jeopardy was removed on 03/23/13 at 6:10 PM</p>	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Kris Thompson* Administrator

TITLE

4-16-13 revised 7-16-13

(X6) DATE

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 60 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 000	Continued From page 1 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and to ensure monitoring systems put into place are effective.  483.25 (F323) at J Immediate Jeopardy began on 02/06/13 when Resident #64 fell from his wheelchair to the van floor while being transported in the facility van. The Administrator was informed of Immediate Jeopardy on 03/22/13 at 10:39 PM. Immediate Jeopardy was removed on 03/23/13 at 4:50 PM when the facility implemented a credible allegation of compliance. The facility remains out of compliance at the lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee education.	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that the alleged deficiencies did, in fact exist. This plan of correction is filed as evidence of the facilities desire to comply with the requirements and to provide high quality care.		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  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.  This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility staff failed to treat a resident with dignity for 1 of 3 residents reviewed for dignity. (Resident #43)	F 241		4/17/13	

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F 241	Continued From page 2  The findings included:  Resident #43 was admitted to the facility 01/16/13 with diagnoses which included glaucoma and blindness. Review of Resident #43's Admission Minimum Data Set (MDS) dated 01/23/13 revealed she was cognitively intact. Further review of the MDS indicated Resident #43 needed extensive assistance with transfer and toileting. The MDS assessed Resident #43 as being occasionally incontinent of bladder.  Review of Resident #43's care plan dated 01/24/13 for urinary incontinence revealed the goal was the resident would maintain/regain urinary continence. Interventions included incontinence management program of prompted toileting.  A form entitled Concern/Grievance Reporting Form dated 03/12/13 was filed with Resident #43's name and resident checked as having reported the allegation. The nature of concern/grievance read, "Resident complained of third shift employees not taking resident to the bathroom. When resident asked she was told to use her brief. She also complained of her bottom being sore." Follow up action read, "Therapy got resident a gel cushion for her chair also suggestion for resident to lie down, resident refused." There was no staff signature on this form noting who took this complaint/grievance.  During an interview on 03/18/13 at 4:34 PM with Resident #43 she stated a staff member told her not to ring her call bell any more because she was not coming back as she had 25 people to	F 241	<b>F241</b> <b>Affected Resident:</b>  <b>For Resident #43</b>  <b>Staff were trained on dignity and respect.</b>  <b>All others with potential To be affected:</b>  <b>An interview sheet was developed To document any resident issues With regard to being treated With respect and dignity.</b>  <b>25 Residents were interviewed With regard staff treatment of residents i.e.: respect and dignity. No other resident voiced any concern regarding respect or dignity.</b>  <b>Measures/systemic changes:</b>  <b>An interview sheet was Developed to document Resident issues with regard to Being treated with respect And dignity.</b>	<b>4/8/13</b> <b>Thru</b> <b>4/17/13</b>  <b>3/20/13</b>  <b>3/20/13</b>	

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F 241	<p>Continued From page 3</p> <p>take care of. Resident #43 stated this person works every weekend starting at 7:00 PM. Resident #43 further stated if she (Nursing Assistant #5) has to come back to take her to the bathroom she "gives it to her" by stating I have more to care for than just you. Resident #43 stated she hated to see the weekend come. Resident #43 stated the way this nursing assistant talks to her makes her feel afraid. Resident #43 stated this nursing assistant worked with her last night.</p> <p>An interview was conducted on 03/19/13 at 4:50 PM with the Director of Nursing (DON) notifying her of the allegation made by Resident #43. She stated she was already investigating the allegation. She stated she had spoken to Resident #43's family member. The DON further stated she had spoken to the accused nursing assistant (NA #5) and she had denied the allegation. The DON stated she thought the resident was confusing the incident with another facility.</p> <p>On 03/21/13 at 11:12 AM an interview was conducted with the Assistant Director of Nursing/Staff Development Coordinator (ADON/SDC). He stated on 03/20/13 he interviewed Resident #43 regarding the allegation she had made and the other residents on B hall. He stated several other residents had concerns regarding nursing assistant attitudes and call bells.</p> <p>An interview was conducted on 03/21/13 at 4:58 PM with the Admission Coordinator. The Admission Coordinator stated she filled out the Concern/Grievance Form when Resident #43</p>	F 241	<p><b>In-service education was initiated On 4/9/13</b></p> <p><b>With facility staff including nursing staff (Licensed and unlicensed), housekeeping, Dietary, administrative, activities, Social service, maintenance and therapy by the SDC/RN: In-service objectives included: Staff will treat residents with respect and dignity at all times, this includes meeting their individual personal needs.</b></p> <p><b>For those staff members who are on Leave from the facility will be in-serviced upon return to the facility prior to assignment. This will be done By the Staff Development Nurse/RN</b></p>	4/9/13 Thru 4/17/13

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F 241	Continued From page 4 reported her bottom was hurting and that she had only been taken to the bathroom once. The Admission Coordinator stated Resident #43 reported she had wanted to go to the bathroom more frequently but no one answered her call bell. The Admission Coordinator further stated that Resident #43 reported to her that staff had told her go the bathroom in her brief.  NA #5 was not available during the survey as she worked weekends 7:00 PM - 7:00 AM and was terminated on 03/22/13.	F 241	<del>Monitoring will continue by utilizing the resident questionnaire for the next 3 months. 10% of residents will be interviewed every other week for the 3 month periods. If any resident had voiced a concern with regard to respect and dignity this will be immediately report to the DON/Administrator and an investigation will be initiated.</del>		
F 242 SS=J	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES  The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to honor a resident's choice for an advanced directive for Do Not Resuscitate (DNR) status and to honor a resident's choice for an advanced directive for full code status in 2 of 2 unresponsive residents. (Residents #114 and #148).  Immediate Jeopardy began on 12/27/12 at 8:00 PM when facility staff did not honor Resident #114's choice for Do Not Resuscitate (DNR) when the resident stopped breathing and	F 242	Ongoing resident interviews will be determined by the results of the prior 3 months of interviews.  QA:  Results of the resident questionnaire will be reviewed at the monthly QA meeting for the next 3 months and continued evaluation will be based on results. Appropriate actions will be taken as appropriate.	4/17/13	

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F 242	<p>Continued From page 5</p> <p>cardiopulmonary resuscitation (CPR) was started. Immediate Jeopardy, was removed on 03/23/13 at 6:10 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and to ensure monitoring systems put into place are effective. Example #2 (Resident #148's code status) was cited at a D level deficiency (an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy).</p> <p>The findings included:</p> <p>1. Resident #114 was admitted on 09/24/12 with diagnoses that included heart disease, high blood pressure, dementia, kidney disease and a stroke with left sided weakness. The resident expired on 12/27/12 at 8:05 PM.</p> <p>A review of the admission Minimum Data Set (MDS) dated 09/24/12 indicated Resident #114 had impairment in short term and long term memory and was moderately impaired in cognition for daily decision making and required extensive assistance from staff for activities of daily living.</p> <p>A review of a yellow form with a red stop sign in the top left hand corner indicated Do Not Resuscitate (DNR) Order dated 09/24/12 with no expiration date.</p>	F 242	<p><b>Credible allegation of compliance</b></p> <p><b>RESIDENT'S RIGHT TO BE INVOLVED IN ADVANCE DIRECTIVES PROCESS</b></p> <p>1. AFFECTED RESIDENT CORRECTIVE ACTION</p> <p>Resident #114 was admitted to the facility on 9/24/12 with diagnosis that included chronic kidney disease, high blood pressure, stroke and dementia. The resident had a do not resuscitate (DNR) order dated 9/24/12.</p>	4/17/13

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F 242	<p>Continued From page 6</p> <p>A review of a document titled "Acknowledgement of Receipt of Advanced Directives Information" dated 09/24/12 had an "x" next to "provided a copy to the facility" for DNR status and was signed by a family member.</p> <p>A review of a Physician's Progress Note with a date of service of 09/25/12 indicated Code Status: Do Not Attempt Resuscitation (DNR/No CPR).</p> <p>A review of a Palliative Care Progress Note dated 09/26/12 indicated Resident #114 remains a DO NOT RESUSCITATE.</p> <p>A review of a physician's order dated 09/26/12 indicated DNR and nurse may pronounce expired and release body to funeral home of choice.</p> <p>A review of a nurse's note dated 12/27/12 at 8:00 PM indicated a Nurse Aide (NA) was with Resident #114 giving incontinence care and called a nurse to the room because the resident was not breathing right. The notes revealed Resident #114 had shallow breathing and then stopped breathing and CPR was started. The notes further indicated Resident #114's chart was checked and the DNR order was found and CPR was stopped at 8:05 PM. The notes revealed Emergency Medical Technicians arrived and Resident #114 was placed on a heart monitor and there was no heart beat and family was notified at 8:15 PM and the funeral home was notified at 9:15 PM.</p> <p>A review of a Coroner/Medical Examiner report dated 12/27/12 indicated in a section titled "Events that have taken place" a NA noted the</p>	F 242	<p>On 12/27/12 at 8:00 pm Resident #114 stopped breathing and cardiopulmonary resuscitation (CPR) was started. The CPR was stopped after the resident's chart was checked and the DNR was noted.</p> <p>2. CORRECTIVE ACTION ACCOMPLISHED FOR ALL RESIDENTS WITH THE POTENTIAL TO BE AFFECTED</p> <p>On 3/12/12 "Admission Audit" was started for all new resident admissions. The Medical Records Information Clerk will use the audit and any concerns will be put on the "Admission Audit Information" form and given to the department that the concern pertains to for correction and follow up. The Admission Audit will be a continuous with necessary changes or necessity being evaluated by the QA committee.</p> <p>Upon admission all residents are given the "Resident and Family Information Handbook" and reviewed. The handbook includes multiple areas that address advanced directives with examples of advanced directives and how advance directive work in a nursing facility. The handbook covers the areas of "should I bring a copy to the nursing facility", "What if I am unable to tell someone I have an advanced directive",</p>		

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F 242	<p>Continued From page 7</p> <p>resident was having shallow respirations then not breathing. The report further indicated a nurse arrived and the resident was pulseless and was not breathing and CPR was started. The report revealed the nursing staff found a DNR order and CPR was discontinued.</p> <p>During an interview on 03/20/13 at 10:14 AM the physician/medical director stated it was his expectation that nursing staff should refer to the resident's chart for code status and if the resident was a DNR they should not resuscitate the resident.</p> <p>During an interview on 03/21/13 at 4:37 PM Nurse #3 stated she remembered Resident #114 and a NA called her to the resident's room because the resident wasn't breathing right. She explained she started to assess Resident #114 and the resident stopped breathing so she gave Resident #114 rescue breathing with an ambu bag and had started chest compressions when someone brought her the resident's chart and she saw the yellow stop sign form and then she stopped everything. She further stated she was not aware of the resident's code status when she went into the resident's room and reacted to start CPR because she was taught to treat the patient when she found them unresponsive. She further stated she should have verified the resident's code status first before she did anything because it was Resident #114's choice to be a DNR. She stated she called the DON after Resident #114 expired but after that no one from administration called her or talked to her about Resident #114 and she was not aware that any interventions or changes made for nurses to verify that the code status was correct on resident's charts.</p>	F 242	<p>"What role does my family play in making my advanced directive", "Do I need to make an advanced directive", "When should I make an advanced directive", "Can I make an advanced directive in a nursing facility", "Can the nurse or social worker explain the form to me", "Do I have to have a lawyer to make an advanced directive" and "Can I change my mind after I make an advanced directive". Admission Coordinator and/or Social Worker designee meets with residents or responsible party to determine their wishes regarding the code status.</p> <p>Resident Council reviews a different resident right each month during the monthly meeting.</p> <p>On 3/20/13 education was provided regarding advance directives and the resident's right to choose their end of life decisions. The objectives of the lesson plan were a) Staff will understand the resident right to make choices on their end of life decisions b) staff will understand documentation requirements related to the residents advanced directives c) Staff will understand who makes decisions regarding DNR status when the resident is unable to communicate their health</p>		



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F 242	<p>Continued From page 8</p> <p>During an interview on 03/21/13 at 5:03 PM the Director of Nursing (DON) stated she expected nursing staff to honor a resident's code status and if the resident was a DNR then CPR should not be started and 2 nurses should confirm that the resident was not breathing and had no pulse and then call the doctor, family and funeral home. She further confirmed that there was no discussion or Resident #114's code in the weekly Administrative Nurse's Meeting of 01/04/13 and confirmed there was no documentation in the meeting minutes. She explained that it was their usual process when there was an incident it should be discussed in the weekly Administrative Nurse's Meeting and action plans developed and interventions put in place to monitor. She also stated she did not remember any discussion at the monthly QA meeting of Resident #114's code status.</p> <p>The Administrator was informed of Immediate Jeopardy on 03/20/13 at 2:37 PM for Resident #148. The following Credible Allegation of Compliance was accepted on 03/23/13 at 6:10 PM.</p> <p>Credible allegation of compliance</p> <p>RESIDENT'S RIGHT TO BE INVOLVED IN ADVANCE DIRECTIVES PROCESS</p> <p>1. AFFECTED RESIDENT CORRECTIVE ACTION</p> <p>Resident #114 was admitted to the facility on 9/24/12 with diagnosis that included chronic kidney disease, high blood pressure, stroke and</p>	F 242	<p>care choices. This in-service was provided to licensed nurses, social worker designee and admissions coordinator. All shifts will be completed including the weekend staff by 3/23/13. Those staff members who are on leave from facility will be in-serviced upon return to facility prior to assignment on the floor. This will be done by Staff Development Coordinator.</p> <p><i>The in-service education was completed on 3/23/13 with licensed nurses, Social Service Designee and the Admissions Coordinator. Any staff that is on vacation, medical leave, etc. will be educated on advanced directives prior to being scheduled.</i></p> <p>Ongoing education regarding advanced directives will be done quarterly for the next year and on orientation. Any employee who is on vacation, family medical leave or any other leave will be educated on advanced directives prior to being assigned to the floor. Each year following, advanced directive education will be done twice a year and on orientation. Any employee who is on vacation, family medical leave or any other leave will be educated on advanced directives prior to being assigned to the floor.</p>		

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F 242	<p>Continued From page 9</p> <p>dementia. The resident had a do not resuscitate (DNR) order dated,9/24/12.</p> <p>On 12/27/12 at 8:00 pm Resident #114 stopped breathing and cardiopulmonary resuscitation (CPR) was started. The CPR was stopped after the resident's chart was checked and the DNR was noted.</p> <p>2. CORRECTIVE ACTION ACCOMPLISHED FOR ALL RESIDENTS WITH THE POTENTIAL TO BE AFFECTED</p> <p>Upon admission all residents are given the "Resident and Family Information Handbook" and reviewed. The handbook includes multiple areas that address advanced directives with examples of advanced directives and how advance directive work in a nursing facility. The handbook covers the areas of "should I bring a copy to the nursing facility", "What if I am unable to tell someone I have an advanced directive", "What role does my family play in making my advanced directive", "Do I need to make an advanced directive", "When should I make an advanced directive", "Can I make an advanced directive in a nursing facility", "Can the nurse or social worker explain the form to me", "Do I have to have a lawyer to make an advanced directive" and "Can I change my mind after I make an advanced directive". Admission Coordinator and/or Social Worker designee meets with residents or responsible party to determine their wishes regarding the code status.</p> <p>Resident Council reviews a different resident right each month during the monthly meeting.</p> <p>On 3/20/13 education was provided regarding</p>	F 242	<p>Resident #148 was admitted to the facility on 3/6/12 at approximately 2:15pm from the hospital. The diagnosis included (per discharge summary): systolic congestive heart failure, ischemic cardiomyopathy with an ejection fraction estimated around 15%, type 2 diabetes, mitral valve prolapse, history of emphysema, known history of coronary artery disease, elevated cholesterol, chronic peripheral edema and bilateral lower extremity pressure wounds. The hospital records indicated the resident had established DO NOT RESUSITATE (DNR). The reason for the resident's admission to the facility was wound care and rehabilitation with ongoing physical therapy.</p> <p>The admission nurse's note indicated the resident was alert and oriented at approximately 2:30 PM. The Admission Coordinator met with the resident's husband on 3/6/12 at approximately 3:30PM in her office at which time the residents husband asked that his wife be a "full code" and signed the Acknowledgement of Advanced Directives Form which indicated the resident was a full code. The Admission Coordinator and the husband went to the resident's room at approximately 4:30PM. At that time the Admission Coordinator observed the resident</p>		

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F 242	<p>Continued From page 10</p> <p>advance directives and the resident's right to choose their end of life decisions. The objectives of the lesson plan were a) Staff will understand the resident right to make choices on their end of life decisions b) staff will understand documentation requirements related to the residents advanced directives c) Staff will understand who makes decisions regarding DNR status when the resident is unable to communicate their health care choices. This in-service was provided to licensed nurses, social worker designee and admissions coordinator. All shifts will be completed including the weekend staff by 3/23/13. Those staff members who are on leave from facility will be in-serviced upon return to facility prior to assignment on the floor. This will be done by Staff Development Coordinator.</p> <p>Ongoing education regarding advanced directives will be done quarterly for the next year and on orientation. Any employee who is on vacation, family medical leave or any other leave will be educated on advanced directives prior to being assigned to the floor. Each year following, advanced directive education will be done twice a year and on orientation. Any employee who is on vacation, family medical leave or any other leave will be educated on advanced directives prior to being assigned to the floor.</p> <p>3. MEASURE/SYSTEMIC CHANGES</p> <p>On 3/11/12 100% of all active resident charts were reviewed by the Admission Coordinator regarding Advanced Directives. She reviewed the Advanced Directive paper work that included, "Acknowledgement of Receipt of Advanced</p>	F 242	<p>unable to communicate and would not open her eyes due to her lethargy. During Resident #148's stay at the facility there were episodes of confusion, delusions and hallucinations</p> <p>validated by nurse's notes dated 3/9/12 and 3/10/12. On 3/9/12 the nurse's notes stated "yelling at staff and spouse saying needles are in her arms, there are no needles in her arms, resident is confused." On 3/10/12 a nurse's note reflected resident stated "seeing things like snakes in her bed."</p> <p>Resident #148 was transported to the hospital by EMS on 3/11/12 due to cardiac arrest and respiratory failure.</p> <p>The Admissions coordinator was contacted by facility staff nurse at approximately 12:30 AM on 3/11/12 regarding Resident #148's advance directives and the staff stated specifically the DNR (yellow form) was on the chart but the resident's husband requested full code status for Resident #148. The Admissions Coordinator came into facility on 3/11/12 at approximately 9:30AM and met with charge nurse to review charts for correct code status. The Admission Coordinator spoke with staff at hospital and obtained a faxed copy of the</p>		

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F 242	<p>Continued From page 11</p> <p>Directive Information" form and if the resident was a DNR that the yellow DNR form was in place. She also checked to see if there were MD orders or other code status. There were not any other concerns identified.</p> <p>An audit tool titled "Advanced Directive Audit" was developed on 3/20/13 which addressed the following: a) is the Advanced Directive Acknowledgement is in place, signed by the resident or Power of Attorney (POA). POA- if resident is unable to communicate wishes) and is on the chart b) If a DNR order is in effect does the "STOP" sign and the MD order match the advanced directive c) Is ordered entered in the computer that matches the resident current code status.</p> <p>On 3/20/13 100% of resident's currently in the facility were audited for a) The Advanced Directive Acknowledgement is in place, signed by the resident or POA (POA- if resident is unable to communicate wishes) and is on the chart b) The DNR orders are in effect does the "STOP" sign and the MD order match the advanced directive c) The orders entered in the computer that match the resident current code status. The results of the audit done on 3/20/13 revealed residents choices had been honored based on the "Acknowledgement of Receipt of Advanced Directive Information" and verified by the resident's signature on multiple "acknowledgement" forms.</p> <p>4. QA</p> <p>The Medical Records Information Clerk will report any "Admission Audit" concerns found on review</p>	F 242	<p>original advance directive at 10:08 AM that had been sent to the hospital with EMS. The Admission Coordinator then reviewed 100% of the resident medical records on 3/11/12 to validate that all advanced directive paper work was in place. The forms included "The Acknowledgment of Advanced Directive Information", yellow DNR form, and MD orders for DNR and/or other code status.</p> <p>3. MEASURE/SYSTEMIC CHANGES</p> <p>On 3/11/12 100% of all active resident charts were reviewed by the Admission Coordinator regarding Advanced Directives. She reviewed the Advanced Directive paper work that included, Acknowledgement of Receipt of Advanced Directive Information" form and if the resident was a DNR that the yellow DNR form was in place. She also checked to see if there were MD orders or other code status. There were not any other concerns identified.</p>		

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F 242	<p>Continued From page 12</p> <p>of the medical record to the Director of Nurses and/or the Administrator at any time the concern is found. This includes incomplete or missing "Acknowledgement of Receipt of Advanced Directive Information" forms and DNR (Yellow form) when there is an order for DNR. The audit tool developed on 3/21/13 will be completed on 10% of the residents per week for 4 weeks, then 10% of the residents every two weeks, then monthly for 3 months. Ongoing audits will continue based on the results of the prior 4 months of audits. Results of the audits will be reviewed at the facility monthly QA meeting. Any "Admission Audit" concerns will be presented at the monthly QA meeting for the committee input and recommendations. If concerns or problems are identified the QA committee will monitor monthly for no less than 3 months. Advanced directive compliance will remain as part of the monthly QA program on an ongoing basis.</p> <p>Immediate jeopardy was removed on 03/23/13 at 6:10 PM when interviews of nursing staff and the Admissions Coordinator confirmed they had received in-service training on advance directives which included full code status and DNR. The nursing staff explained they were taught that it was a resident's choice to make decisions regarding their advanced directives and code status and if they were not able to make the decision, a responsible party could make the decision for them. They stated it was the resident's choice to change their mind about advanced directives and they could sign new code status forms at any time. Nursing staff explained they were expected to always check the resident's chart first when they found a resident unresponsive so that they would provide</p>	F 242	<p>An audit tool titled "Advanced Directive Audit" was developed on 3/20/13 which addressed the following:</p> <p>a) is the Advanced Directive Acknowledgement is in place, signed by the resident or Power of Attorney (POA). POA- if resident is unable to communicate wishes) and is on the chart b) If a DNR order is in effect does the "STOP" sign and the MD order match the advanced directive c) Is ordered entered in the computer that matches the resident current code status.</p> <p>On 3/20/13 100% of resident's currently in the facility were audited for</p> <p>a) The Advanced Directive Acknowledgement is in place, signed by the resident or POA (POA- if resident is unable to communicate wishes) and is on the chart b) The a DNR orders are in effect does the "STOP" sign and the MD order match the advanced directive c) The orders entered in the computer that match the resident current code status. The results of the audit done on 3/20/13 revealed residents choices had been honored based on the</p>		

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F 242	<p>Continued From page 13</p> <p>CPR if the resident was a full code and they should not start CPR on a resident who had DNR orders.</p> <p>Record reviews were also made to verify accurate code status was available in the front of the resident's medical record. The Admissions Coordinator verified all new admissions would have chart audits completed and documented to ensure the correct advanced directives and code status forms were present on the resident's chart.</p> <p>The new Advanced Directive Audit tool was reviewed and contained documentation of record reviews that had been completed of resident records to confirm the correct forms for advanced directives, code status forms and physician's orders were in place on resident's charts.</p> <p>2. Resident #148 was admitted to the facility on 03/06/12 with diagnoses which included heart failure, mitral valve prolapse (heart problem in which the valve that separates the upper and lower chambers of the left side of the heart does not close), coronary artery disease (narrowing of the small blood vessels that supply blood and oxygen to the heart.), type 2 diabetes, emphysema and chronic swelling in her lower legs with pressure wounds on both lower legs. Resident #148 was transported to the hospital by Emergency Medical Services (EMS) on 03/11/12 and expired.</p> <p>A review of a form that was a bright yellow color with a red stop sign in the top left hand corner indicated a Do Not Resuscitate (DNR) order that was dated 03/01/12 prior to Resident #148's</p>	F 242	<p>"Acknowledgement of Receipt of Advanced Directive Information" and verified by the resident's signature on multiple "acknowledgement" forms.</p> <p>4. QA</p> <p>The Medical Records Information Clerk will report any "Admission Audit" concerns found on review of the medical record to the Director of Nurses and/or the Administrator at any time the concern is found. This includes incomplete or missing "Acknowledgement of Receipt of Advanced Directive Information" forms and DNR (Yellow form) when there is an order for DNR. The audit tool developed on 3/21/13 will be completed on 10% of the residents per week for 4 weeks, then 10% of the residents every two weeks, then monthly for 3 months. Ongoing audits will continue based on the results of the prior 4 months of audits. Results of the audits will be reviewed at the facility monthly QA meeting. Any "Admission Audit" concerns will be presented at the monthly QA meeting for the committee input and recommendations. If concerns or problems are identified the</p>		

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F 242	<p>Continued From page 14 discharge from the hospital on 03/06/12.</p> <p>A review of a hospital discharge summary dated 03/06/12 indicated Resident #148 was hospitalized from 02/20/12 until she was discharged to the facility on 03/06/12. The hospital discharge summary contained a note by a physician that indicated in part, after explaining heart failure to both the patient and her spouse, they agreed to a DNR status, although they still wished to pursue active management of her heart failure if possible. The discharge summary further indicated Resident #148 had shown enough progress by her discharge date of 03/06/12 that Resident #148 could be transferred to rehabilitation with ongoing physical therapy and wound care.</p> <p>A review of a facility document titled "Social Service Progress Note" dated 03/06/12 at 2:00 PM and signed by the Admissions Coordinator indicated Resident #148 was admitted from the hospital to the facility and the facility policy and procedures and admission paperwork were reviewed with Resident #148's spouse. The notes revealed code status was reviewed in great length and detail and the spouse was aware that a DNR had been completed in the hospital however, Resident #148's condition had improved and she was no longer considered to be terminal and was changed to a full code status at the facility.</p> <p>A facility document that was white in color and titled Acknowledgment of Receipt of Advanced Directives Information dated 03/06/12 indicated an "x" next to the statement "am not interested - I am a full code" and was signed by Resident</p>	F 242	<p>QA committee will monitor monthly for no less than 3 months. Advanced directive compliance will remain as part of the monthly QA program on an ongoing basis.</p>	

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F 242	<p>Continued From page 15 #148's spouse.</p> <p>A review of "Medicare Notes" dated 03/06/12 indicated Resident #148 was alert and oriented.</p> <p>A review of "Medicare Notes" dated 03/07/12 indicated Resident #148 was oriented to person and place.</p> <p>A review of "Medicare Notes" dated 03/08/12 indicated Resident #148 was yelling at staff and spouse and said needles were in her arms but there were no needles in her arms and the resident was confused.</p> <p>A review of "Medicare Notes" dated 03/09/12 indicated Resident #148 was crying and was seeing things like snakes in her bed.</p> <p>A review of a physician's progress note dated 03/09/12 indicated Resident #148 was alert and oriented to person and place but had difficulty with short-term memory and did not know the year.</p> <p>A review of the 5 Day Minimum Data Set (MDS) Discharge assessment dated 03/11/12 indicated Resident #148 was cognitively intact and was totally dependent on staff for transfers and required extensive assistance from staff for bathing and dressing.</p> <p>A review of "Medicare Notes" dated 03/11/12 indicated Resident #148 "expired."</p> <p>A review of a nurse's note dated 03/11/12 at 12:15 AM indicated Resident #148 was having shallow breathing and was non-responsive and</p>	F 242		
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F 242	<p>Continued From page 16</p> <p>the resident's spouse was called to inform him of his wife's condition. The notes further indicated when on the phone with the spouse a Nurse Aide (NA) informed the nurse that Resident #148 was not breathing. The notes revealed the nurse checked Resident #148's vital signs and there was no blood pressure or heart rate and the spouse was informed of Resident #148's condition and then CPR was started.</p> <p>A review of an EMS report dated 03/11/12 indicated EMS was called at 12:44 AM and arrived at Resident #148's room at 12:50 AM. A section of the EMS report titled "Activity" indicated Resident #148 had shallow respirations and nursing staff called the resident's spouse. The report revealed the nursing staff told the spouse they had Resident #148 listed as a DNR but he told them that she had been changed to a full code and requested they start CPR and send the resident to the hospital.</p> <p>A review of a facility document titled "Discharge Summary Form" dated 03/20/12 indicated Resident #148's discharge diagnosis was cardiac/respiratory failure.</p> <p>During a phone interview on 03/19/13 at 3:54 PM with Nurse #1 she explained Nurse #2 (night shift charge nurse) told her Resident #148 had no pulse or blood pressure around 12:15 AM on 03/11/12 and Nurse #2 called the resident's spouse and told him the resident had expired. She stated Nurse #2 reported that the resident's spouse asked her if she was going to start CPR and she told him according to their paperwork she was a DNR. She stated Nurse #2 told her that Resident #148's spouse said he said she</p>	F 242		
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F 242	<p>Continued From page 17</p> <p>was a full code and should be resuscitated and Nurse #2 got off the phone and started CPR on Resident #148.</p> <p>During a follow up interview on 03/20/13 at 1:27 PM the Admissions Coordinator explained that during the admission process if a resident was alert and coherent enough then she talked to the resident about their admission forms which included advanced directives and code status but if they were not coherent she talked to the family/responsible party. She explained residents sometimes were compromised or confused and then a family member who was the responsible party signed the paper work for the resident. The Admission Coordinator verified the resident or responsible party could change the code status at any time and once the paperwork was signed it was recognized as a legally binding document by the facility. The Admissions Coordinator explained she routinely had the responsible party sign all of the resident's admission forms which included advanced directives and code status forms during the admission process and she was not concerned about Resident #148's spouse signing Resident #148's full code form because he was listed as her primary responsible party. She further explained she tried to talk to Resident #148 on 03/06/13 after she was admitted but she was very lethargic, kept her eyes closed and did not seem coherent enough to sign the forms. She confirmed she had Resident's 148's spouse sign all of the admission forms which included the Full Code form and verified she did not attempt any other conversations about code status with Resident #148.</p> <p>During a follow up interview on 03/20/13 at 2:00</p>	F 242			

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F 242	<p>Continued From page 18</p> <p>PM the Admissions Coordinator verified she put the white form titled "Acknowledgment of Receipt of Advanced Directives Information" dated 03/06/12 that indicated Resident #148 was a full code in the front of the resident's chart behind the first tab so the nurses could flip to it quickly. She also verified she didn't look through Resident 148's chart but if she had realized the yellow DNR form was on the chart she would have removed it.</p> <p>During an interview on 03/23/13 at 3:38 PM Nurse #7 stated on 03/11/12 after midnight she and Nurse #2 were at the nurses station and a NA came to the desk and told them to come to Resident #148's room. She explained she took one look at Resident #148 and told Nurse #2 to call the resident's spouse because Resident #148 looked like she was already gone. She further explained Resident #148 was unresponsive and had no pulse. She stated she left the room and went to the nurses station to check the resident's chart for code status and Nurse #2 was on the phone with the resident's spouse and told him Resident #148 was gone. Nurse #7 further stated the spouse was very upset and told them Resident #148 was a full code and they better resuscitate her and so they started CPR. Nurse #7 explained the code for Resident #148 was a nightmare because of the confusion regarding her code status and she was concerned that Resident #148's choice of code status was not honored.</p> <p>During an interview on 03/21/13 at 5:03 PM the Director of Nursing (DON) stated she expected nursing staff to honor a resident's code status and if the resident was a full code then CPR should be started immediately. She further</p>	F 242		
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NAME OF PROVIDER OR SUPPLIER  <b>PEAK RESOURCES - SHELBY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1101 NORTH MORGAN STREET BOX 2287 SHELBY, NC 28150</b>
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F 242	Continued From page 19 confirmed that there was no discussion of Resident #148's code status or the events that occurred on 03/1,1/12 in the weekly Administrative Nurse's Meeting on 03/16/12 and confirmed there was no documentation in the meeting minutes. She explained that it was their usual process when there was an incident it should be discussed in the weekly Administrative Nurse's Meeting and action plans should be developed and interventions put in place to monitor. She also stated she did not remember any discussion at the monthly QA meeting regarding Resident #148's code status.	F 242		
F 272 SS=D	<p><b>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</b></p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:          Identification and demographic information;          Customary routine;          Cognitive patterns;          Communication;          Vision;          Mood and behavior patterns;          Psychosocial well-being;          Physical functioning and structural problems;          Continence;          Disease diagnosis and health conditions;          Dental and nutritional status;          Skin conditions;</p>	F 272	<p><b>F 272 Comprehensive Assessment Resident #125</b></p> <p>There was no adverse affect to resident #125 regarding pressure ulcer status. The resident was readmitted with a stage 4 pressure ulcer on 2/11/13(sacrum). All MD wound notes indicated from readmission through 3/21/13 "Improved" noted under the "wound progress" question.</p>	3/27/13

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F 272	<p>Continued From page 20</p> <p>Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to comprehensively assess the pressure ulcer for 1 of 3 sampled residents with pressure ulcers. (Resident #125).</p> <p>The findings included:</p> <p>Resident #125 was admitted to the facility on 07/26/12. His diagnoses included anoxic brain injury, traumatic crush injury of the chest with tension and acute hemorrhage from the lungs, hypertension, anxiety, dysphasia, and decubitus ulcer on his sacrum.</p> <p>The admission Minimum Data Set (MDS) dated 08/06/12 coded Resident #125 with no speech, being rarely understood, understands, and no cognitive assessment per resident interview or staff interview for mental status. He was coded as being nonambulatory, requiring extensive</p>	F 272	<p>Residents with potential:</p> <ol style="list-style-type: none"> <li>1. One to one in-service was completed with the facility MDS nurse with regard to completion of the CAA and the care plans by the Corporate MDS trained RN.</li> <li>2. Any staff member who is assigned to MDS/CAA's completion will be trained prior to being assigned to work.</li> <li>3. Those MDS's completed in the month of March 2013 were reviewed for appropriate description of the resident problem, causes and contributing factors to specific resident problems. Updates and revisions were completed as necessary. Care plans were developed/updated/revised as necessary.</li> </ol> <p><b>Monitoring:</b></p> <p>An audit tool was developed to monitor the appropriateness of the CAA and care plan. The tool included questions related to: does the CAA describe the problems, causes and contributing factors related to resident problems; is there analysis of the specific resident issue/problem; Is there a care plan developed for resident specific issues identified by the CAA analysis. This tool will be completed by the Director of Nurses and in his absence an MDS prepared/trained RN will complete the audit.</p> <p>All regularly scheduled MDS/CAA's and care plans will be reviewed/audited weekly over the next 60 days. Then 50% of all regularly scheduled MDS's CAA's and care plans will be reviewed/audited over the next 30 days for a total of 3 months. Continued audits will be determined by the results of the prior 3 months of auditing.</p>	3/27/13
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F 272	<p>Continued From page 21</p> <p>assistance for all activities of daily living skills (ADLS) and having 2 stage 2 pressure ulcers, with one present on admission. The Care Area Assessment (CAA) related to pressure ulcers was dated 08/10/12 and stated the resident had a stage 2 ulcer on his sacrum, was tube fed, had an indwelling urinary catheter and required total care.</p> <p>Per record review, Resident #125 was admitted to the hospital on 08/31/12 due to a fever of 102.7 degrees Fahrenheit. He was readmitted on 09/06/12. A significant change MDS dated 09/12/12 coded Resident #125 with 1 stage 3 pressure ulcer on readmission. The Care Area Assessment (CAA) related to pressure ulcers was dated 09/25/12. Under the section for "Analysis of findings" was in total "stage 3 wound on sacral area. See cognitive caa". The CAA related to cognition stated he had a "stage 3 sacral decub ulcer." This CAA also noted his recent hospitalization for sepsis, the use of a tracheostomy, tube feeding, inability to communicate, his very stiff body posture at times, he was receiving palliative care, and recent weight loss despite tube feeding calorie increase. The CAA did not document the description of the problem, causes and contributing factors and risk factors related to pressure ulcers. There was no analysis of the resident's strengths, weaknesses, special needs to consider and why the CAA noted no care plan would be developed.</p> <p>Per record review, Resident #125 was hospitalized on 02/03/13 and was readmitted to the facility on 02/11/13 with the diagnoses of sepsis and a stage 4 pressure ulcer (on his sacrum). The most recent quarterly MDS dated</p>	F 272	<p>QA:</p> <p>The results of the monthly audits will be reviewed at the monthly QA committee meeting for the next 3 months and continued evaluation will be based on results. System changes will be evaluated and discussed and changes will be made if necessary.</p>	

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F 272	<p>Continued From page 22</p> <p>02/22/13 coded Resident #125 with long and short term memory impairments, severely impaired decision making skills and requiring extensive to total care for all ADLS and having a stage 4 pressure ulcer.</p> <p>On 3/20/13 at 10:30 AM Resident #125's sacral area was observed with the Wound Care Nurse. The sacral wound was clean, moist, beefy red with granulation tissue surrounding the open wound.</p> <p>On 03/22/13 at 2:09 PM the MDS coordinator was interviewed. She stated that she completed the pressure sore section of the MDS for Resident #125. She further stated she also completed Resident #125's CAAs. She stated that Resident #125 could not move himself, turn himself, had splints, was stiff, had weight loss and that put anyone at risk for pressure ulcers.</p> <p>On 03/23/13 at 5:12 PM, the Director of Nursing (DON) stated the MDS coordinator went through training with MDS 3.0 initially and will be going to prescheduled class.</p> <p>On 03/23/13 at 5:32 PM, the corporate MDS nurse reviewed the pressure ulcer CAA dated 09/25/12. She stated that the CAA should paint a picture of Resident #125, including if he was admitted with the pressure ulcer, if the stage or size increased and why he had the pressure ulcer. She confirmed the CAA needed more analysis information.</p>	F 272		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged</p>	F 280		4/10/13

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F 280	Continued From page 23 incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to update a pressure sore care plan to include wound care physician's recommendations for 1 of 3 sampled residents reviewed for pressure ulcers. (Resident #125).  The findings included:  Resident #125 was admitted to the facility on 07/26/12. His diagnoses included anoxic brain injury, traumatic crush injury of the chest with tension and acute hemorrhage from the lungs, hypertension, anxiety, dysphasia, and decubitus ulcer on his sacrum.	F 280	Resident # 125 had the care plan revised to reflect specific positioning requirements.  There was no adverse effect to resident #125 regarding pressure ulcer status. The resident was readmitted with a stage 4 pressure ulcer on 2/11/13 (sacrum).  All wound MD notes indicated From readmission through 3/21/13 "Improved" noted under "wound Progress".  Residents with potential:  A "Wound Recommendation Review" Form was developed to document The following: Wound MD recommendations ordered by Attending MD; the resident care plan updates and has the care plan been revised; etc. 4/10/13 This will be completed by The wound RN weekly post the Wound MD visit.  The wound nurse (BSN) reviewed All of the wound Physicians Recommendations and appropriate Follow up was accomplished. 3/22/13	4/10/13            3/22/13



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F 280	<p>Continued From page 24</p> <p>The admission Minimum Data Set (MDS) dated 08/06/12 coded Resident #125 with no speech, being rarely understood, understands, and no cognitive assessment per resident interview or staff interview for mental status. He was coded as being nonambulatory, requiring extensive assistance for all activities of daily living skills (ADLS) and having 2 stage 2 pressure ulcers, with one present on admission.</p> <p>Per record review, Resident #125 was admitted to the hospital on 08/31/12 due to a fever of 102.7 degrees Fahrenheit. He was readmitted on 09/06/12. A significant change MDS dated 09/12/12 coded Resident #125 with 1 stage 3 pressure ulcer on readmission.</p> <p>Review of the wound physician's weekly notes revealed from 01/02/13 through 01/16/13 the physician recommended the facility staff off load wound, limit sitting to 60 minutes and reposition the resident per facility protocol. Review of the wound physician's weekly notes revealed from 01/23/13 to 01/31/13 the physician recommended the facility staff off load wound, limit sitting to 2 hours except during treatments and reposition the resident per facility protocol.</p> <p>Per record review, Resident #125 was hospitalized on 02/03/13 and was readmitted to the facility on 02/11/13 with the diagnoses of sepsis and a stage 4 pressure ulcer (on his sacrum).</p> <p>The care plan dated 02/12/13 which addressed the current stage 4 pressure ulcer had goals to minimize the potential for infection and to manage discomfort associated with altered skin condition.</p>	F 280	<p><b>Monitoring/systemic changes:</b></p> <p>"The wound recommendation" form Will be completed weekly for 3 months For all resident who are seen by The wound physician. Ongoing Reviews will be determined by the Prior 3 month review results.</p> <p>Care plans will be updated and revised Based on physician orders and facility Protocol.</p> <p><b>QA:</b></p> <p>Results of the "Wound Recommendation Review" form will be discussed and reviewed at the monthly QA committee meeting. This will be done over the next 3 months. Continued monitoring will done based on the prior 3 months of monitoring. Follow-up/Further action will be taken as necessary.</p>		

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F 280	<p>Continued From page 25</p> <p>Interventions included weekly skin assessments, indwelling urinary catheter, air mattress, wound physician with weekly consults, turn and reposition frequently during rounds and as needed, and the specific treatment of Collasorb with dressing every other day as ordered by the physician. The wound care physician's recommendation for off loading the wound and to limit sitting to 2 hours was not added to the care plan:</p> <p>The most recent quarterly MDS dated 02/22/13 coded Resident #125 with long and short term memory impairments, severely impaired decision making skills and requiring extensive to total care for all ADLS and having a stage 4 pressure ulcer. The wound care physician's recommendation for off loading the wound and to limit sitting to 2 hours was not added to the care plan at this time.</p> <p>Review of the wound physician's weekly notes revealed from 02/14/13 through 03/07/13 the physician recommended the facility staff off load wound, limit sitting to 2 hours except during treatments and reposition the resident per facility protocol.</p> <p>The care plan was updated on 02/28/13 with a new treatment order of Ca Alginate and Santyl to the sacrum wound. The care plan was also updated on 03/14/13 for the treatment change to Hydrogel gauze to sacral wound.</p> <p>Review of the undated Resident Care Information Sheet used by the nurse aides for reference for care plan interventions revealed instructions to assist the resident to turn and reposition, use an air mattress, and use a gel pad in the gerichair.</p>	F 280		

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F 280	<p>Continued From page 26</p> <p>There were no instructions related to limiting the time Resident #125 stays up in a chair.</p> <p>On 3/20/13 at 9:14 AM Nurse Aide (NA) #2 and the Wound Nurse were observed transferring Resident #125 from bed to a gerichair which contained a full length gel cushion. Resident #125 was observed sitting in the gerichair on 03/20/13 at 10:05 AM and 1:06 PM.</p> <p>On 3/20/13 at 10:30 AM Resident #125's sacral area was observed with the Wound Care Nurse. The sacral wound was clean, moist, beefy red with granulation tissue surrounding the open wound.</p> <p>On 03/20/13 at 1:12 PM NA #2 stated Resident #125 had been in the gerichair since she transferred him into the chair this morning. She stated she had repositioned him upright because he tended to lean to the side. She confirmed he had not been out of the chair since the earlier observation. NA #2 stated she did not get Resident #125 up everyday and the amount of time she left him up in the gerichair depended on his pain level. When asked if Resident #125 had any time restrictions on being up in the chair, NA #2 stated she was unaware of any limitations.</p> <p>On 03/20/13 at 1:45 PM, Resident #125 was observed in bed lying on his back.</p> <p>On 03/21/13 at 10:32 AM the wound care physician was interviewed. He stated that he had been following Resident #125's wounds weekly since November. The physician stated that his recommendation for Resident #125 to sit up in a chair no longer than 2 hours was needed to</p>	F 280		
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F 280	Continued From page 27 promote wound healing. The wound care nurse present with the wound care physician at this time stated she was aware of this recommendation and had told the nurse aides, nurses and the weekend wound care nurse. The wound care nurse further stated Resident #125 was very rigid and staff had to be careful when turning and positioning him.  During interview on 03/21/13 at 4:56 PM, NA #4 stated there are no guidelines or time frames for Resident #125 relating to how long he should be up or in bed.  During interview on 03/21/13 at 4:58 PM, NA # 3 stated she cared for Resident #125 every Thursday. NA #3 stated sometimes the resident was up in the gerichair when she started her shift and she left him up a little then transferred him back to bed. When asked if there were any specific time frames or time limits he could be up in the gerichair, she answered "Not that I know of."	F 280			
	On 03/22/13 at 2:09 PM, MDS Coordinator stated the wound care nurse developed and implemented Resident #125's pressure ulcer care plan. Per the MDS Coordinator the care plan was updated by the wound care nurse.  The wound care nurse was interviewed on 03/22/13 at 4:05 PM. She stated she verbally informed all pertinent nursing staff of the residents with wound and what needs to be done related to care needs. She further stated she informed all nurses and nurse aides that Resident #125 needed to be limited to his gerichair for only 2 hours. The wound care nurse further stated she				

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F 280	Continued From page 28 had failed to put this recommendation on the care plan used by the nurses and on the Resident Care Information Sheet used by the nurse aides.  On 03/22/13 at 4:14 PM, the Director of Nursing (DON) stated the wound care nurse normally followed through with any recommendations made by the wound care physician. She further stated she expected the recommendation to be on the care plan and on the Resident Care Information Sheet.	F 280		
F 309 SS=J	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 record reviews and staff interviews the facility staff provided cardiopulmonary resuscitation (CPR) on a resident whose advanced directives indicated Do Not Resuscitate and the facility staff failed to implement emergency medical interventions and start CPR immediately on a resident with an advanced directive for full code status in 2 of 2 unresponsive residents. (Residents #114 and #148).  Immediate Jeopardy began on 12/27/12 at 8:00 PM when facility staff did not honor Resident	F 309	PROCESS TO ESTABLISH CODE STATUS ON ADMISSION  1. AFFECTED RESIDENT CORRECTIVE ACTION  Resident #114 was admitted to the facility on 9/24/12 with diagnosis that included chronic kidney disease, high blood pressure, stroke and dementia. The resident had a do not resuscitate (DNR) order dated 9/24/12.  On 12/27/12 at 8:00 pm Resident #114 stopped breathing and cardiopulmonary resuscitation (CPR) was started. The CPR was stopped after the resident's chart was checked and the DNR was noted.	4/17/13

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F 309	<p>Continued From page 29</p> <p>#114's choice for Do Not Resuscitate (DNR) when the resident stopped breathing and cardiopulmonary resuscitation (CPR) was started. Immediate Jeopardy was removed on 03/23/13 at 6:10 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and to ensure monitoring systems put into place are effective. Example #2 (Resident #148's code status) was cited at a D level deficiency (an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy).</p> <p>The findings included:</p> <p>A review of a facility policy titled "Do Not Resuscitate Order" with a revised date of March 2004 indicated the following policy statement "our facility will not use cardiopulmonary resuscitation and related emergency measures to maintain life functions on a resident when there is a Do Not Resuscitate Order in effect."</p> <p>A review of a facility policy titled Cardiopulmonary Resuscitation (CPR) dated October 2006 indicated the facility routinely instructs staff with regard to who is responsible for providing CPR, the location of emergency equipment and contact information for outside services (i.e. Emergency Medical Services (EMS)/911).</p> <p>1. Resident #114 was admitted on 09/24/12 with diagnoses that included heart disease, high blood</p>	F 309	<p>Resident #148 was admitted to the facility on 3/6/12 at approximately 2:15 PM from the hospital. The diagnosis included (per discharge summary): systolic congestive heart failure, ischemic cardiomyopathy with an ejection fraction estimated around 15%, type 2 diabetes, mitral valve prolapse, history of emphysema, known history of coronary artery disease, chronic peripheral edema and bilateral lower extremity pressure wounds. The hospital records indicated the resident had established DO NOT RESUSITATE (DNR). The reason for the resident's admission to the facility was wound care and rehabilitation with ongoing physical therapy.</p> <p>On 3/6/12 the admission nurse's note indicated the resident was alert and oriented at approximately 2:30 PM. The Admission Coordinator met with the resident's husband on 3/6/12 at approximately 3:30PM in her office at which time the residents husband asked that his wife be a "full code". The Admission Coordinator and the husband went to the resident's room at approximately 4:30PM. At that time the Admission Coordinator observed the resident unable to communicate and would not open her eyes due to her lethargy. The Admission Coordinator is unable to recall any other visits to the room and verified the resident's husband signed the Acknowledgement of Advanced Directive Information which indicated the resident was a full code. During Resident #148's stay at the facility, there were episodes of confusion, delusions and hallucinations validated by nurse's notes dated 3/9/12 and 3/10/12. On 3/9/12 the nurse's notes stated "yelling at staff and spouse saying needles are in her arms, there are no needles in her arms, resident is confused." On 3/10/12 a nurse's note reflected resident stated "seeing things like snakes in her bed."</p>	
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NAME OF PROVIDER OR SUPPLIER  PEAK RESOURCES - SHELBY	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 SHELBY, NC 28150
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F 309	<p>Continued From page 30 pressure, dementia, kidney disease and a stroke with left sided weakness. The resident expired on 12/27/12 at 8:05 PM.</p> <p>A review of the admission Minimum Data Set (MDS) dated 09/24/12 indicated Resident #114 had impairment in short term and long term memory and was moderately impaired in cognition for daily decision making and required extensive assistance from staff for activities of daily living.</p> <p>A review of a yellow form with a red stop sign in the top left hand corner indicated Do Not Resuscitate (DNR) Order dated 09/24/12 with no expiration date.</p> <p>A review of a document titled "Acknowledgement of Receipt of Advanced Directives Information" dated 09/24/12 had an "x" next to "provided a copy to the facility" for DNR status and was signed by a family member.</p> <p>A review of a Physician's Progress Note with a date of service of 09/25/12 indicated Code Status: Do Not Attempt Resuscitation (DNR/No CPR).</p> <p>A review of a Palliative Care Progress Note dated 09/26/12 indicated Resident #114 remains a DO NOT RESUSCITATE.</p> <p>A review of a physician's order dated 09/26/12 indicated DNR and nurse may pronounce expired and release body to funeral home of choice.</p> <p>A review of a nurse's note dated 12/27/12 at 8:00 PM indicated a Nurse Aide (NA) was with</p>	F 309	<p>Resident #148 was transported to the hospital by EMS on 3/11/12 due to cardiac arrest and respiratory failure.</p> <p>The Admissions coordinator was contacted by facility staff nurse at approximately 12:30 AM on 3/11/12 regarding Resident #148's advance directives and the staff stated specifically the DNR (yellow form) was on the chart but the resident's husband had requested full code status for Resident #148. The Admission Coordinator verbalized she would be at the facility in the morning to review charts for resident code status. The Admissions Coordinator came into facility on 3/11/12 at approximately 9:30 AM and met with charge nurse to review charts for correct code status. Admission Coordinator also spoke with staff at hospital and obtained a faxed copy of the original advance directive at 10:08 AM that had been sent to the hospital with EMS. On 3/11/12 the Admission Coordinator then reviewed 100% of the resident medical records to validate all advanced directive paper work were in place. The forms included "The Acknowledgment of Advanced Directive Information", yellow DNR form, and MD orders for DNR and/or other code status.</p>	3/11/12
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F 309	<p>Continued From page 31</p> <p>Resident #114 giving incontinence care and called a nurse to the room because the resident was not breathing right. The notes revealed Resident #114 had shallow breathing and then stopped breathing and CPR was started. The notes further indicated Resident #114's chart was checked and the DNR order was found and CPR was stopped at 8:05 PM. The notes revealed Emergency Medical Technicians arrived and the Resident #114 was placed on a heart monitor and there was no heart beat and family was notified at 8:15 PM and the funeral home was notified at 9:15 PM that Resident #114 had expired.</p> <p>A review of a Coroner/Medical Examiner report dated 12/27/12 indicated in a section titled "Events that have taken place" a NA noted the resident was having shallow respirations then not breathing. The report further indicated a nurse arrived and the resident was pulse less and was not breathing and CPR was started. The report revealed the nursing staff found a DNR order and CPR was discontinued.</p> <p>During an interview on 03/20/13 at 10:14 AM the physician/medical director stated it was his expectation that nursing staff should refer to the resident's chart for code status and if the resident was a DNR they should not resuscitate the resident.</p> <p>During an interview on 03/21/13 at 4:37 PM Nurse #3 stated she remembered Resident #114 and a NA called her to the resident's room because the resident was breathing but wasn't breathing right. She explained she started to assess Resident #114 and the resident stopped breathing so she tried to reposition the resident</p>	F 309	<p>2. CORRECTIVE ACTION ACCOMPLISHED FOR ALL RESIDENTS WITH THE POTENTIAL TO BE AFFECTED</p> <p>Education was provided to licensed nurses and the Admission Coordinator on 5/8/12 regarding the right to make choices in regards to when Advanced Directives should be made, who makes the advanced directive decisions and changing the advanced directive after it has been established and end of life decision making. On Monday morning, 3/12/12 the Admissions Coordinator discussed with the Director of Nurses (DON) the conflicting code status of Resident #148, and plans to address these concerns. They discussed auditing of all new</p>	5/8/12	



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F 309	<p>Continued From page 32</p> <p>and gave the resident a sternal rub and described it as a firm and vigorous pressure of the resident's chest to stimulate the resident to breathe but she did not start breathing. She stated she then gave Resident #114 rescue breathing with an ambu bag and was starting to do chest compressions when someone brought her the resident's chart and she saw the yellow stop sign form and she stopped everything. She further stated she then called the resident's family, the physician and the Director of Nursing and told them Resident #114 had expired.</p> <p>During an interview on 03/21/13 at 5:03 PM the Director of Nursing (DON) stated she did not remember if Nurse #3 called her on 12/27/12 regarding Resident #114. She stated Nurse #3 should not have started rescue breathing with an ambu bag or performed the sternal rub or started chest compressions until she checked the chart and determined what the resident's code status was.</p> <p>The Administrator was informed of Immediate Jeopardy on 03/20/13 at 2:37 PM for Resident #148. The following Credible Allegation of Compliance was accepted on 03/23/13 at 6:10 PM.</p> <p>Credible Allegation of Compliance</p> <p>PROCESS TO ESTABLISH CODE STATUS ON ADMISSION</p> <p>1. AFFECTED RESIDENT CORRECTIVE ACTION</p> <p>Resident #114 was admitted to the facility on</p>	F 309	<p>admissions for code status including looking for any conflicting code status information related to MD orders. The next newly admitted resident's chart was reviewed on 3/14/12 by the Medical Record Information Clerk. An audit form was created titled "Admission Audit" and had a section titled "Acknowledgement of Advanced Directive" to check this as completed. The Medical Record Information Clerk looked for the "Acknowledgement of Advanced Directive Information" form in the chart. If the resident was a DNR she looked to see if the yellow DNR form was in place. If anything was missing it would be reported by the Medical Record Clerk to the Admissions Coordinator and/or Social Worker Designee with a written note that described the area which was out of compliance. The staff member who received the written notification regarding any compliance issues corrected the chart then gave the completed written signed and dated notice back to the Medical records Information Clerk.</p>	

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F 309	<p>Continued From page 33</p> <p>9/24/12 with diagnosis that included chronic kidney disease, high blood pressure, stroke and dementia. The resident had a do not resuscitate (DNR) order dated 9/24/12.</p> <p>On 12/27/12 at 8:00 pm Resident #114 stopped breathing and cardiopulmonary resuscitation (CPR) was started. The CPR was stopped after the resident's chart was checked and the DNR was noted.</p> <p><b>2. CORRECTIVE ACTION ACCOMPLISHED FOR ALL RESIDENTS WITH THE POTENTIAL TO BE AFFECTED</b></p> <p>On 3/20/13 education was conducted regarding advance directives and the resident's right to choose their end of life decisions. The objectives of the lesson plan were: a) Staff will understand the resident's right to make choices on their end of life decisions b) staff will understand documentation requirements related to the residents advanced directives c) Staff will understand who makes decisions regarding DNR status when the resident is unable to communicate their health care choices. This in-service was provided to licensed nurses, social worker designee and admissions coordinator. All shifts will be completed including the weekend staff by 3/23/13. Those staff members who are on leave from facility will be in-serviced upon return to facility prior to assignment on the floor. This will be done by Staff Development Coordinator.</p> <p>Ongoing education regarding advanced directives will be done quarterly for the next year and on orientation. Any employee who is on vacation,</p>	F 309	<p>On 3/20/13 education was conducted regarding advance directives and the resident's right to choose their end of life decisions. The objectives of the lesson plan were: a) Staff will understand the resident's right to make choices on their end of life decisions b) staff will understand documentation requirements related to the residents advanced directives c) Staff will understand who makes decisions regarding DNR status when the resident is unable to communicate their health care choices. This in-service was provided to licensed nurses, social worker designee and admissions coordinator. All shifts will be completed including the weekend staff by 3/23/13. Those staff members who are on leave from facility will be in-serviced upon return to facility prior to assignment on the floor. This will be done by Staff Development Coordinator.</p> <p>Ongoing education regarding advanced directives will be done quarterly for the next year and on orientation. Any employee who is on vacation, family medical leave or any other leave will be educated on advanced directives prior to being assigned to the floor. Each year following, advanced directive education will be done twice a year and on orientation. Any employee who is on vacation, family medical leave or any other leave will be educated on advanced directives prior to being assigned to the floor.</p> <p>Advanced Directive Information is also reflected in the "Resident and Family Information Handbook" which is provided to all admission and re-admission residents/families.</p>	<p>3/20/13</p> <p>3/23/13</p>
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F 309	<p>Continued From page 34</p> <p>family medical leave or any other leave will be educated on advanced directives prior to being assigned to the floor. Each year following, advanced directive education will be done twice a year and on orientation. Any employee who is on vacation, family medical leave or any other leave will be educated on advanced directives prior to being assigned to the floor.</p> <p>Advanced Directive Information is also reflected in the "Resident and Family Information Handbook" which is provided to all admission and re-admission residents/families.</p> <p><b>3. MEASURE/SYSTEMIC CHANGES</b></p> <p>The "Admission Audit" tool is completed by the Medical Records Information Clerk to identify any advance directive issues. The audit is completed for all new admissions and re-admissions. The Medical Records Information Clerk checks the section on the audit form titled "Acknowledgement of Advanced Directive" only if the "Acknowledgement of Advanced Directive Information" and all DNR information are in the chart. If there is any conflicting code status information she reports this to the Admission Coordinator and/or Social Worker designee. She then follows up with a written note that describes the area which is out of compliance; the member involved with any compliance issues, corrects the chart then gives the completed written, signed and dated notice back to the Medical Records Information Clerk.</p> <p>A new audit tool titled Advanced Directive Audit was developed on 3/21/13 to address the following: 1. Resident has received</p>	F 309	<p><b>3. MEASURE/SYSTEMIC CHANGES</b></p> <p>The "Admission Audit" tool is completed by the Medical Records Information Clerk to identify any advance directive issues. The audit is completed for all new admissions and re-admissions. The Medical Records Information Clerk checks the section on the audit form titled "Acknowledgement of Advanced Directive" only if the "Acknowledgement of Advanced Directive Information" and all DNR information are in the chart. If there is any conflicting code status information she reports this to the Admission Coordinator and/or Social Worker designee. She then follows up with a written note that describes the area which is out of compliance; the member involved with any compliance issues, corrects the chart then gives the completed written, signed and dated notice back to the Medical Records Information Clerk.</p> <p>A new audit tool titled Advanced Directive Audit was developed on 3/21/13 to address the following: 1. Resident has received</p>	3/21/13	

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F 309	<p>Continued From page 35</p> <p>documentation regarding advance directives. 2. Has the resident been given an opportunity to make a decision about his or her end of life. 3. Advanced directive care plan has been initiated on admission and reviewed quarterly. 4. Does the physician order reflect the resident wishes. 5. Has advanced Directives been discussed with any significant change.</p> <p>Since 3/12/12 approximately 175 "Admission Audits" have been completed on all newly admitted resident's and had advanced directives or Do Not Resuscitate, full code and doctor's orders in place. There were no concerns identified.</p> <p>The policy on advanced directives has been updated and revised to include the CMS memorandum revision dated 9/27/2012 which included health decision making capacity, establishing advanced directives, informing and educating the resident about these rights, advanced care planning and legal representative.</p> <p>4. QA</p> <p>The Medical Records Information Clerk will report any "Admission Audit" concerns found on review of the medical record to the Director of Nurses and/or the Administrator at any time the concern is found. This includes incomplete or missing "Acknowledgement of Receipt of Advanced Directive Information" forms and DNR (Yellow form) when there is an order for DNR. The audit tool developed on 3/21/13 was completed on 100 % of resident's currently in the facility. Monitoring will continue and be completed on 10% of the residents per week for 4 weeks, then 10% of the</p>	F 309	<p>Since 3/12/12 approximately 175 "Admission Audits" have been completed on all newly admitted resident's and had advanced directives or Do Not Resuscitate, full code and doctor's orders in place. There were no concerns identified.</p> <p>The policy on advanced directives has been updated and revised to include the CMS memorandum revision dated 9/27/2012 which included health decision making capacity, establishing advanced directives, informing and educating the resident about these rights, advanced care planning and legal representative.</p>	3/20/13	

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F 309	<p>Continued From page 36</p> <p>residents every two weeks, then monthly for 3 months. Ongoing audits will continue based on the results of the prior 4 months of audits. Results of the audits will be reviewed at the facility monthly QA meeting. Any "Admission Audit" concerns will be presented at the monthly QA meeting for the committee input and recommendations. If concerns or problems are identified the QA committee will monitor monthly for no less than 3 months. Advanced directive compliance will remain as part of the monthly QA program on an ongoing basis.</p> <p>Immediate jeopardy was removed on 03/23/13 at 6:10 PM when interviews with nursing staff and the Admissions Coordinator confirmed they had received in-service training on advance directives which included full code status or DNR for residents. The nursing staff explained when a resident was unresponsive they should check the resident's chart for advanced directives and code status first and if the resident was a full code they should start CPR immediately but if the resident was a DNR they should not start CPR and they should notify the family and physician that the resident had expired.</p> <p>Record reviews were also done to verify accurate code status was available in the front of the resident's medical record. The Admissions Coordinator verified all new admissions would have chart audits to ensure the correct advanced directives and code status forms were present on the resident's chart.</p> <p>The new Advanced Directive Audit tool was reviewed and contained documentation of record reviews that had been completed of resident</p>	F 309	<p>QA</p> <p>The Medical Records Information Clerk will report any "Admission Audit" concerns found on review of the medical record to the Director of Nurses and/or the Administrator at any time the concern is found. This includes incomplete or missing "Acknowledgement of Receipt of Advanced Directive Information" forms and DNR (Yellow form) when there is an order for DNR. The audit tool developed on 3/21/13 was completed on 100 % of resident's currently in the facility. Monitoring will continue and be completed on 10% of the residents per week for 4 weeks, then 10% of the residents every two weeks, then monthly for 3 months. Ongoing audits will continue based on the results of the prior 4 months of audits. Results of the audits will be reviewed at the facility monthly QA meeting. Any "Admission Audit" concerns will be presented at the monthly QA meeting for the committee input and recommendations. If concerns or problems are identified the QA committee will monitor monthly for no less than 3 months. Advanced directive compliance will remain as part of the monthly QA program on an ongoing basis.</p> <p>The new audit tool has not identified any trend or pattern regarding advanced directives</p>	4/17/13	

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F 309	<p>Continued From page 37</p> <p>records to confirm the correct forms for advanced directives, code status forms and physician's orders were in place on resident's charts.</p> <p>2. Resident #148 was admitted to the facility on 03/06/12 with diagnoses which included heart failure, mitral valve prolapse (heart problem in which the valve that separates the upper and lower chambers of the left side of the heart does not close), coronary artery disease (narrowing of the small blood vessels that supply blood and oxygen to the heart.), type 2 diabetes, emphysema and chronic swelling in her lower legs with pressure wounds on both lower legs. Resident #148 was transported to the hospital by Emergency Medical Services (EMS) on 03/11/12 and expired.</p> <p>A review of a form that was a bright yellow color with a red stop sign in the top left hand corner indicated a Do Not Resuscitate (DNR) order that was dated 03/01/12 prior to Resident #148's discharge from the hospital on 03/06/12.</p> <p>A review of a hospital discharge summary dated 03/06/12 indicated Resident #148 was hospitalized from 02/20/12 until she was discharged to the facility on 03/06/12. The hospital discharge summary contained a note by a physician that indicated in part, after explaining the situation to both the patient and spouse, they agreed to a DNR status, although they still wished to pursue active management of her heart failure if possible. The discharge summary further indicated Resident #148 had had shown enough progress by her discharge date of 03/06/12 that Resident #148 could be transferred to rehabilitation with ongoing physical therapy and</p>	F 309		
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F 309	Continued From page 38 wound care.  A review of a facility document titled "Social Service Progress Note" dated 03/06/12 at 2:00 PM and signed by the Admissions Coordinator indicated Resident #148 was admitted from the hospital to the facility and the facility policy and procedures and admission paperwork were reviewed with Resident #148's spouse. The notes revealed code status was reviewed in great length and detail and the spouse was aware that a DNR had been completed in the hospital but he stated since her condition had improved and she was admitted to the facility for rehabilitation that Resident #148 wanted to be a full code.  A review of the 5 Day Minimum Data Set (MDS) Discharge Assessment dated 03/11/12 indicated Resident #148 was cognitively intact and was totally dependent on staff for transfers and required extensive assistance from staff for bathing and dressing.	F 309			
	A facility document that was white in color and titled "Acknowledgment of Receipt of Advanced Directives Information" dated 03/06/12 indicated an "x" next to the statement "am not interested - I am a full code."  A review of "Medicare Notes" dated 03/11/12 indicated Resident #148 "expired."  A review of a nurse's note dated 03/11/12 at 12:15 AM indicated Resident #148 was having shallow breathing and was non-responsive and the resident's spouse was called to inform him of his wife's condition. The notes further indicated when on the phone with the spouse a Nurse Aide				

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F 309	<p>Continued From page 39</p> <p>(NA) informed the nurse that Resident #148 was not breathing. The notes revealed the nurse checked Resident #148's vital signs and there was no blood pressure or heart rate and the spouse was informed of Resident #148's condition and then CPR was started. The notes indicated Emergency Medical Services (EMS) and the physician were called and EMS arrived in approximately 5 minutes, assisted with CPR and continued CPR while Resident #148 was transported to the hospital.</p> <p>A review of an EMS report dated 03/11/12 indicated EMS was called at 12:44 AM and arrived at Resident #148's room at 12:50 AM. A section of the EMS report titled "Activity" indicated Resident #148 had shallow respirations and nursing staff had called the resident's spouse. The report revealed the nursing staff told the spouse they had Resident #148 listed as a DNR but he told them that she had been changed to a full code and requested they send the resident to the hospital. The report further revealed the nursing staff stated approximately 20 minutes had passed since they were in the room with Resident #148 and when they went back in her room she had no pulse and was not breathing and they started CPR. The report indicated Resident #148 was placed on a heart monitor but did not have a pulse or heart beat, her face and lips were blue and Resident #148 was transported with CPR in progress to the emergency room.</p> <p>A review of a hospital report titled "Emergency Department Documentation" dated 03/11/12 indicated Resident #148 was found unresponsive at the facility and had been reported to have had</p>	F 309		
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F 309	<p>Continued From page 40</p> <p>some difficulty with her breathing earlier. The report further indicated Resident #148 had no response to treatment and CPR was unsuccessful.</p> <p>A review of a facility document titled "Discharge Summary Form" dated 03/20/12 indicated Resident #148's discharge diagnosis was cardiac/respiratory failure.</p> <p>During a phone interview on 03/19/13 at 3:54 PM with Nurse #1 she stated she worked every weekend from 7:00 AM until 11:00 PM and was told about Resident #148 when she was given report by Nurse #2 on 03/11/12 at 7:00 AM. She explained Nurse #2 told her Resident #148 had no pulse or blood pressure around 12:15 AM and Nurse #2 called the resident's spouse and told him the resident had expired. She stated Nurse #2 reported that the resident's spouse asked her if she was going to start CPR and she told him according to their paperwork she was a DNR. Nurse #1 stated Nurse #2 told her that Resident #148's spouse asked if they had a defibrillator and they should go shock her and do everything they could to save her life. She further stated Nurse #2 said she told him they did not have a defibrillator but she got off the phone and started CPR on Resident #148. She further explained if a resident was found unresponsive they were supposed to go look at the chart first to see what the resident's code status was and if they were a full code they were supposed to page code blue overhead and take the crash cart to the room and start CPR right away. She further explained the nurse aides' responsibility during the code was to get whatever supplies the nurse needed, call EMS and keep the resident hallways clear.</p>	F 309		
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F 309	<p>Continued From page 41</p> <p>During an interview on 03/20/13 at 8:15 AM the Medical Record Information Clerk/ Nurse Scheduler explained she had to work the 7:00 PM to 7:00 AM shift on 03/11/12 because a NA had called in and she could not find anyone else to cover the shift. She stated she did not remember hearing a code paged during the night of 03/11/12 and did not go in Resident #148's room or provide care to her.</p> <p>During a phone interview on 03/20/13 at 8:42 AM with Nurse #2 she verified she no longer worked at the facility but confirmed she worked there on 03/11/12 during the 11:00 PM to 7:00 AM shift and remembered Resident #148. She stated the resident was found unresponsive by a NA and the NA came and told her. She explained she went to Resident #148's room and checked the resident's vital signs and there was no pulse or blood pressure and the resident did not respond. She stated she then went to get the resident's chart to check the resident's code status and she saw a yellow form with a red stop sign on it that said DNR. She further stated she remembered it was a bright yellow color and it caught her eye when she opened the chart. She verified she did not see a white form for full code status in Resident #148's chart. She explained if a resident had a DNR order they usually called the family when the resident expired so she called Resident #148's spouse and he asked her if they were doing anything to resuscitate her. She stated she told him they were not resuscitating her because she was a DNR and he got very upset and told her Resident #148's DNR had been changed to a full code. She explained she hung up the phone and got the crash cart and</p>	F 309		
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F 309	<p>Continued From page 42</p> <p>started CPR. She stated she estimated it was at least 8-10 minutes from the time she found Resident #148 unresponsive with no pulse or blood pressure to the beginning of CPR. She further stated she did chest compressions while Nurse #7 gave rescue breathing with an ambu bag. She explained EMS arrived while they were doing CPR and EMS continued CPR and transported Resident #148 to the hospital. She stated after Resident #148 left with EMS she called the Admissions Coordinator and the Admissions Coordinator confirmed that Resident #148's code status had been changed and she was a full code status.</p> <p>During an interview on 03/20/13 at 9:18 AM the Admissions Coordinator verified Nurse #2 called her in the middle of the night on 03/11/12 and stated Nurse #2 told her the DNR yellow stop form was in Resident #148's chart and did not know the resident was a full code until the resident's spouse told her. The Admissions Coordinator confirmed the yellow DNR form with the red stop sign was the form the resident had while she was in the hospital and it should not have been in the front of Resident #148's chart because Resident #148 had been changed to a full code status when she was admitted to the facility. She further stated the white full code form should have been in the front of the chart instead of the DNR form. The Admissions Coordinator explained she reviewed the advance directive forms in great detail with Resident #148's spouse and he told her that Resident #148 wanted to be a full code unless she was in a terminal condition and since she had made progress and was sent to the facility for rehabilitation she should be a full code.</p>	F 309		

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F 309	Continued From page 43  During an interview on 03/20/13 at 9:40 AM the Director of Nursing (DON) explained a resident's code status was supposed to be determined on admission. She stated when a resident was found unresponsive it was her expectation for nurses to check the resident's code status in the resident's chart first and if the resident was a full code they should call code blue immediately, start CPR and call 911. She explained nursing staff has a basic crash cart available with a suction machine, IV start kit and ambu bag. She stated when 911 was called EMS usually arrived within 5 minutes because the hospital was only 2 blocks away. She explained nursing staff was supposed to page code blue overhead on the call system and all nurses and nurse aides should go to the resident's room and nurses should do chest compressions and rescue breathing with the ambu bag and the nurse aides should get equipment or supplies for the nurses.  During an interview on 03/20/13 at 10:14 AM the physician/medical director stated it was his expectation when a resident was found unresponsive and was a full code that nursing staff should attempt CPR. He further stated the nursing staff should refer to the resident's chart for code status and if the resident was a full code they should resuscitate the resident but if the resident was a DNR they should not resuscitate the resident.  During a follow up interview on 03/20/13 at 2:00 PM the Admissions Coordinator verified she put the white form titled "Acknowledgment of Receipt of Advanced Directives Information" dated 03/06/12 that indicated Resident #148 was a full	F 309			

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F 309	<p>Continued From page 44</p> <p>code in the front of the chart behind the first tab so the nurses could flip to it quickly. She also verified she didn't look through Resident 148's chart but if she had seen the yellow DNR form she would have taken it off the chart.</p> <p>During an interview on 03/23/13 at 12:00 PM with Nurse #6 she stated she was the day shift charge nurse on weekends and the night shift charge nurse usually reported off to her. She verified Nurse #2 was the night shift charge nurse on 03/11/12 and told her when they checked on Resident #148 around 12:30 AM she was not breathing and was unresponsive. She explained she remembered it because Nurse #2 called Resident #148's spouse and he told them to get the paddles out and resuscitate her because she was a full code. Nurse #6 stated Nurse #2 reported to her that she hung up the phone and then started CPR on Resident #148. Nurse #6 stated Nurse #2 also reported to her that she saw the yellow DNR form on the resident's chart and that was why she did not start CPR.</p> <p>During an interview on 03/23/13 at 3:38 PM Nurse #7 stated on 03/11/12 after midnight she and Nurse #2 were at the nurses station and a NA came to the desk and told them to come to Resident #148's room. She explained she took one look at Resident #148 and told Nurse #2 to call the resident's spouse because Resident #148 looked like she was gone. She explained Resident #148 was unresponsive and had no pulse. She explained she left the room and went to the nurses station to check the resident's chart for code status and Nurse #2 was on the phone with the resident's spouse and told him Resident #148 was gone. Nurse #7 stated the husband</p>	F 309			

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F 309	Continued From page 45 was upset and told them they better resuscitate her. She stated they started CPR and EMS came and left with CPR in progress on Resident #148 but the code was a nightmare.	F 309			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to limit the time spent in a chair per the wound physician recommendations for 1 of 3 sampled residents with pressure ulcers. (Resident #125).  The findings included:  Resident #125 was admitted to the facility on 07/26/12. His diagnoses included anoxic brain injury, traumatic crush injury of the chest with tension and acute hemorrhage from the lungs, hypertension, anxiety, dysphasia, and decubitus ulcer on his sacrum.  The admission Minimum Data Set (MDS) dated 08/06/12 coded Resident #125 with no speech, being rarely understood, understands, and no	F 314	F314  Resident #125 had the care plan revised to reflect specific positioning requirements. 4/11/13  There was no adverse Effect to resident #125 Regarding pressure ulcer Status. The resident was Readmitted with a stage4 Pressure ulcer on 2/11/13. (sacrum). All wound MD notes indicated From readmission through 3/21/13 "Improved" noted under "wound Progress" by the MD.  Residents with potential:  In-service was provided to nursing staff regarding prevention of pressure ulcers this included but was not limited to: turning and positioning, off-loading pressure areas, use of cushions and mattresses, reporting skin changes to licensed nurses/MD and incontinence care. This was done by the Staff Development Nurse/RN.	4/11/13          4/11/13 Thru 4/17/13	

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F 314	<p>Continued From page 46</p> <p>cognitive assessment per resident interview or staff interview for mental status. He was coded as being nonambulatory, requiring extensive assistance for all activities of daily living skills (ADLS) and having 2 stage 2 pressure ulcers, with one present on admission.</p> <p>Per record review, Resident #125 was admitted to the hospital on 08/31/12 due to a fever of 102.7 degrees Fahrenheit. He was readmitted on 09/08/12. A significant change MDS dated 09/12/12 coded Resident #125 with 1 stage 3 pressure ulcer on readmission.</p> <p>Review of the wound physician's weekly notes revealed from 11/14/12 through 12/19/12 the physician recommended the facility staff off load wound and reposition the resident per facility protocol. Review of the wound physician's weekly notes revealed from 01/02/13 through 01/16/13 the physician recommended the facility staff off load wound, limit sitting to 60 minutes and reposition the resident per facility protocol. Review of the wound physician's weekly notes revealed from 01/23/13 to 01/31/13 the physician recommended the facility staff off load wound, limit sitting to 2 hours except during treatments and reposition the resident per facility protocol.</p> <p>Per record review, Resident #125 was hospitalized on 02/03/13 and was readmitted to the facility on 02/11/13 with the diagnoses of sepsis and a stage 4 pressure ulcer (on his sacrum).</p> <p>The most recent quarterly MDS dated 02/22/13 coded Resident #125 with long and short term memory impairments, severely impaired decision</p>	F 314	<p>Any employee who is on vacation, medical leave, etc will be educated prior to their return to work.</p> <p>A "Wound Recommendation Review" Form was developed to document The following: Wound MD recommendations ordered by Attending MD; the resident care plan updates and has the care plan been revised as well as were the NA can find the recommendations/facility protocols necessary to implement for their assigned resident. 4/10/13</p> <p>The wound nurse (BSN) reviewed All of the wound Physicians Recommendations and appropriate Follow-up was accomplished. 3/22/13</p> <p>Monitoring/systemic changes:</p> <p>An audit tool was developed which addresses observation of residents for turning and positioning, proper positioning with cushions, wedges, etc. shifting weight while in a chair, Incontinence care and off- loading.</p>	

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F 314	<p>Continued From page 47</p> <p>making skills and requiring extensive to total care for all ADLS and having a stage 4 pressure ulcer.</p> <p>The care plan dated 02/12/13 which addressed the current stage 4 pressure ulcer had goals to minimize the potential for infection and to manage discomfort associated with altered skin condition. Interventions included weekly skin assessments, indwelling urinary catheter, air mattress, wound physician with weekly consults, turn and reposition frequently during rounds and as needed, and the specific treatment of Collasorb with dressing every other day as ordered by the physician. This care plan was updated on 02/28/13 with a new treatment order of Ca Alginate and Santyl to the sacrum wound. The care plan was most recently updated on 03/14/13 for the treatment change to Hydrogel gauze to sacral wound.</p> <p>Review of the wound physician's weekly notes revealed from 02/14/13 through 03/07/13 the physician recommended the facility staff off load wound, limit sitting to 2 hours except during treatments and reposition the resident per facility protocol.</p> <p>Review of the undated Resident Care Information Sheet used by the nurse aides for reference for care plan interventions revealed instructions to assist the resident to turn and reposition, use an air mattress, and use a gel pad in the gerichair. There were no instructions related to limiting the time Resident #125 stays up in a chair.</p> <p>On 3/20/13 at 9:14 AM Nurse Aide (NA) #2 and the Wound Nurse entered Resident #125's room to provide care and transfer him to a gerichair.</p>	F 314	<p>The observation audit will be completed by the wound nurse or other RN in her absence on 25% of the resident weekly for 8 weeks, then 25% of the resident every 2 weeks for 1 month and then 25% of the resident monthly for the next 2 months. Ongoing audits will be determined by the prior 5 months of observational audits.</p> <p>The "Wound Recommendation Review" form will be completed on 100% of the resident seen by the wound physician. This will be done weekly over the next 3 months.</p> <p>QA: Results of the Resident Observation audit will be discussed and reviewed at the monthly QA committee meeting. Ongoing audits will be done based on the prior 3 months of audits. Further changes will be made as appropriate.</p> <p>Results of the "Wound recommendation Review" form will be reviewed monthly at the QA committee meeting. Ongoing reviews will be completed based on the prior 3 months of audits. Further changes will be made as appropriate.</p>	<p>3/22/13</p> <p>4/10/13</p>



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F 314	<p>Continued From page 48</p> <p>Resident #125 was nonverbal and exhibited stiff bilateral upper and lower extremities and jerky movements. Resident #125 was transferred to the gerichair, which was covered by a full length gel pad, via a total mechanical lift.</p> <p>On 3/20/13 at 10:30 AM Resident #125's sacral area was observed with the Wound Care Nurse. The sacral wound was clean, moist, beefy red with granulation tissue surrounding the open wound.</p> <p>Resident #125 was observed sitting in the gerichair on 03/20/13 at 10:05 AM and 1:06 PM.</p> <p>On 03/20/13 at 1:12 PM NA #2 stated Resident #125 had been in the gerichair since she transferred him into the chair this morning. She stated she had repositioned him upright because he tended to lean to the side. She confirmed he had not been out of the chair since the earlier observation. NA #2 stated she did not get Resident #125 up everyday and the amount of time she left him up in the gerichair depended on his pain level. When asked if Resident #125 had any time restrictions on being up in the chair, NA #2 stated she was unaware of any limitations.</p> <p>On 03/20/13 at 1:45 PM, Resident #125 was observed in bed lying on his back.</p> <p>On 03/21/13 at 10:32 AM the wound care physician was interviewed. He stated that he had been following Resident #125's wounds weekly since November. The physician stated that his recommendation for Resident #125 to sit up in a chair no longer than 2 hours was needed to promote wound healing. The wound care nurse</p>	F 314			

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F 314	<p>Continued From page 49</p> <p>present with the wound care physician at this time stated she was aware of this recommendation and had told the nurse aides, nurses and the weekend wound care nurse. The wound care nurse further stated Resident #125 was very rigid and staff had to be careful when turning and positioning him.</p> <p>During interview on 03/21/13 at 4:56 PM, NA #4 stated there are no guidelines or time frames for Resident #125 relating to how long she should be up or in bed.</p> <p>During interview on 03/21/13 at 4:58 PM, NA # 3 stated she cared for Resident #125 every Thursday. NA #3 stated sometimes the resident was up in the gerichair when she started her shift and she left him up a little then transferred him back to bed. When asked if there were any specific time frames or time limits he could be up in the gerichair, she answered "Not that I know of."</p>	F 314			
	<p>On 03/22/13 at 2:09 PM, MDS Coordinator stated the wound care nurse developed and implemented Resident #125's pressure ulcer care plan. Per the MDS Coordinator the care plan was updated by the wound care nurse.</p> <p>The wound care nurse was interviewed on 03/22/13 at 4:05 PM. She stated she verbally informed all pertinent nursing staff of the residents with wound and what needs to be done related to care needs. She further stated she informed all nurses and nurse aides that Resident #125 needed to be limited to his gerichair for only 2 hours. The wound care nurse further stated she had failed to put this recommendation on the care</p>				

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F 314	Continued From page 50 plan used by the nurses and on the Resident Care Information Sheet used by the nurse aides. She confirmed that she had updated the Resident Care Information Sheet since the survey began. The wound care nurse also stated that she normally did not write a physician's order for recommendations made by the wound care physician and staff know to minimize the time a resident with a pressure ulcer on their sacrum spent in a chair.  On 03/22/13 at 4:14 PM, the Director of Nursing (DON) stated the wound care nurse normally followed through with any recommendations made by the wound care physician. She further stated she expected the recommendation to be on the care plan and on the Resident Care Information Sheet. The DON stated Resident #125 should not have been in his gerichair longer than 2 hours.	F 314		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff interviews, and resident interviews, the facility failed to secure 1 of 6 sampled residents in the facility van. Resident #64 fell to the floor from his	F 323	F 323  AFFECTED RESIDENT CORRECTIVE ACTION  Resident #64 was admitted on 10/4/12 with diagnosis including end stage renal disease, high blood pressure and on hemodialysis. On 2/6/13 while being transported in the facility van from dialysis when resident became uncomfortable and shifting around in the wheelchair. When the driver stopped at the stop sign the resident slid from the wheelchair to the floor and bumped his head. Investigation by the administrator and DON revealed seatbelt was unbuckled. Neurochecks were initiated and were in normal limits. Resident had no complaints of pain from incident.	4/17/13

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F 323	<p>Continued From page 51</p> <p>wheelchair while being transported in the facility van.</p> <p>Immediate Jeopardy began on 02/06/13 when Resident #64 fell from his wheelchair to the van floor while being transported in the facility van. Immediate Jeopardy was removed on 03/23/13 at 4:50 PM when the facility implemented a credible allegation of compliance. The facility remains out of compliance at the lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee education.</p> <p>The findings included:</p> <p>Nursing notes dated 08/03/12 at 6:35 AM revealed that a resident was being transported in the facility van when Van Driver #1 "brought resident back to facility due to resident falling backwards out of wheelchair. On call Dr. (doctor) notified and made aware of small area noted to back of head raised."</p> <p>The Administrator was interviewed on 03/21/13 at 1:23 PM regarding the transport incident that occurred on 08/03/12 and the measures implemented by the facility to prevent reoccurrence. The Administrator stated the van driver involved with the 08/03/13 van incident was not sure how the straps were attached to the resident's wheelchair at any of the points. The Administrator stated that he had to assume the straps were not correctly placed on the wheelchair, and maybe the straps were on the bars and slid when the van was in motion. The Administrator further stated that on 08/03/12 the</p>	F 323	<p><b>CORRECTED ACTION ACCOMPLISHED FOR RESIDENTS WITH THE POTENTIAL TO BE AFFECTED</b></p> <p>All residents who are transported in the facility van have the potential to be affected.</p> <p>Corrective action for event on 2/6/13: On 2/6/13, Van inspected for proper mechanical functioning of resident wheelchair securement system including floor tracks, tie downs, shoulder straps and lift mechanism was done by administrator and maintenance director and no mechanical problems were found. Specific driver in 2/6/13 incident was suspended from driving on 2/6/13 by the administrator until the investigation was completed. A drug test of the employee by staff development coordinator on 2/6/13 was negative. All transportation staff were given a written quiz "driving safety" which included information on seatbelts on 2/6/13-2/7/13. A return demonstration of the wheelchair securement and in-servicing was completed on 2/6/13-2/7/13.</p> <p><b>MEASURES/SYSTEMIC CHANGES</b></p> <p>Corrective action for event on 2/6/13:</p> <p>The New transportation safety program implemented on 2/6/13 included new videos, "Doing it right," "Driving Safely," and "Braun Lift". Transportation observation audit tool was utilized to include the following: Were proper techniques used to place the</p>	On 2/6/13
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F 323	<p>Continued From page 52</p> <p>following plan and actions were put into place:</p> <ul style="list-style-type: none"> <li>*Van Driver #1 was suspended, drug tested and subsequently not permitted to drive again;</li> <li>*An investigation was initiated to determine the possible cause of the incident;</li> <li>*The van was inspected for proper mechanical functioning;</li> <li>* The resident ' s wheelchair was inspected and anti-tippers were placed on the wheelchair;</li> <li>*All transportation staff were re-educated with return demonstration regarding proper use of "tie down" technique by the Administrator;</li> <li>*All transportation staff had to view the video "Transporting Residents with Special Needs." After the video staff had to take a quiz. Review of this quiz revealed only one question specifically related to securing residents and wheelchairs in the van which had to do with "seat belts are recommended for the driver and all passengers";</li> <li>*An observation audit tool was developed including: were proper techniques used to place the resident into the van; were proper techniques used to secure the resident such as seat belts, tie downs; were proper techniques used to operate the hydraulic van lift; were proper techniques used to unload the resident from the van; and is there documentation the employee has been educated regarding proper use of the equipment/van;</li> <li>*The observation audit tool was used randomly on transportation staff twice a week for six weeks, then weekly for four weeks and then monthly for six months.</li> </ul> <p>Resident #84 was admitted to the facility on 10/04/12 with diagnoses including renal insufficiency, viral hepatitis, hypertension, diabetes, and cerebral vascular accident.</p>	F 323	<p>resident into the van, were proper tech, used to secure resident i.e. attach seat belts, ties downs, etc., were proper techniques used to operate hydraulic van lift, were proper techniques used to unload the resident from the van, is there documentation the employee has been educated regarding proper use of the equipment/van. All transportation staff was educated and observed an additional return demonstration of transportation observation audit tool. Transportation staff was randomly audited by the administrator and maintenance director monthly.</p> <p>On 3/22/13 all in-house facility resident transports were suspended. The transportation observation tool was revised on 3/22/13 to include the following additions:</p> <ul style="list-style-type: none"> <li>• Are tie downs observed at approximately 45 degrees?</li> <li>• Are the tie downs secured at each corner of the wheelchair?</li> </ul> <p>The transportation staff was re-educated on transportation policy and procedures to include the videos, "Doing It right," "Driving Safely," and "Braun Lift" and a completed revised transportation observation tool and return demonstration of wheelchair securement in the van. The transportation staff will not be allowed to transport any resident until all training has been completed.</p>	
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F 323	<p>Continued From page 53</p> <p>The admission Minimum Data Set (MDS), dated 10/11/12, coded Resident #64 as usually being understood, having clear speech, understanding, and requiring extensive to total assistance with most activities of daily living skills (ADLS). The MDS noted "No" on the section for conducting a brief interview for mental status and the section for staff assessment for mental status indicated he had long and short term memory impairments and had some difficulty with decision making in new situations only. The most recent quarterly MDS, dated 01/14/13, coded Resident #64 with long and short term memory impairments and having moderately impaired decision making abilities. His ADLS remained the same. Both MDS assessments included he received dialysis.</p> <p>Review of nursing notes dated 02/06/13 at 6:20 AM revealed Resident #64 slid out of the wheelchair in facility van while being transported back to the facility. The note stated the wheelchair was locked down. Per this note, the resident stated "I slid out of wc (wheelchair) + (and) hit my head" and "I just want to be (symbol for) changed + (and) go back to dialysis." The nursing note indicated he had no raised areas noted on head and no pain with range of motion.</p> <p>Review of the Resident Incident/Accident report revealed "Resident slid out of chair on facility van while chair locked down." There were no injuries or reports of pain.</p> <p>Review of the facility's investigation of this incident included a signed written statement from Van Driver #2 with handwritten notations from the Director of Nursing and statements from Resident</p>	F 323	<p>The transportation observation tool involving multiple drivers will be done five times a week for two weeks by the administrator or maintenance director.</p> <p>Then, three times a week for four weeks by the administrator or maintenance director.</p> <p>Then, weekly for three months by the administrator or maintenance director.</p>	4/17/13

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F 323	<p>Continued From page 54</p> <p>#64 taken by the DON. The van was inspected on 02/06/13 and noted 2 seat buckle clips were bent and clip tracks were cleaned out. Van Driver #2 was suspended. Per interview with the Administrator on 03/21/13 at 1:23 PM, these seat buckle clips were not used at the time of the incident and were found in the van in a box of spare equipment.</p> <p>Van Driver #2's written statement dated 02/06/13 stated she picked up Resident #64 from dialysis and was returning him to the facility because he had to use the bathroom. The statement said "I locked to (sic) chair down and strapped him with all four ties. I got out of dialysis parking lot got to stop sign and he slid out of the chair. I don't know whether he was shifting in the chair because he was still having a BM (bowel movement) because he kept saying I'm still doing it, or if he hit the chair lock." Handwritten questions and answers written by the DON dated 02/06/13 under Van Driver #2's signature were as follows: "Did you have the shoulder + lap straps in place?" "No." "Why didn't you?" "afraid I would get 'poop' on me because he kept saying 'still doing it.'" The DON stated during interview on 03/21/13 at 2:52 PM that she asked these questions for clarification of Van Driver #2's written statement and these were her responses.</p> <p>On 03/21/13 at 5:40 PM, a telephone interview was conducted with Van Driver #2. Van Driver #2 stated she started driving the van in August 2012 and received training which included watching videos, training in the van, riding with another driver and having to demonstrate securing a</p>	F 323	<p>QA</p> <p>The revised transportation audit tool includes:</p> <ul style="list-style-type: none"> <li>• Were proper techniques used to place the resident into the van?</li> <li>• Were proper techniques, used to secure resident i.e. attach seat belts, ties downs, etc.?</li> <li>• Were proper techniques used to operate hydraulic van lift?</li> <li>• Were proper techniques used to unload the resident from the van?</li> <li>• Is there documentation the employee has been educated regarding proper use of the equipment/van?</li> <li>• Are tie downs observed at approximately 45 degrees?</li> <li>• Are the tie downs secured at each corner of the wheelchair?</li> </ul> <p>The transportation observation tool involving multiple drivers will be done five times a week for two weeks by the administrator or maintenance director.</p> <p>Then, three times a week for four weeks by the administrator or maintenance director.</p> <p>Then, weekly for three months by the administrator or maintenance director.</p>	3/23/13.
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F 323	<p>Continued From page 55</p> <p>wheelchair into the van in front of the Administrator. She further stated the Administrator just observed her securing another staff member sitting in a wheelchair in the van last week. According to Van Driver #2, she drove residents to dialysis Monday through Friday mornings. She stated on the day of 02/06/13, she had been called back to dialysis because Resident #64 was sick and needed to use the bathroom. Resident #64 had diarrhea and was very squirmy. She described the time as "chaotic" and stated it was dark at that time of the morning. She recounted that she secured the wheelchair to the van but could not specifically recall putting the lap belt and shoulder belt in place. She described herself as being very diligent using the lap/shoulder belts. Per Van Driver #2, Resident #64 had already begun to be incontinent when she picked him up from dialysis. She said she did not remember what happened other than he slid out of the chair. The surveyor read Van Driver #2 the questions and answers written by the DON on her statement. She said she really could not remember and was very upset about the incident. She stated Resident #64 was very alert and oriented and would have been physically able to unfasten his lap and shoulder belt. A followup phone interview on 3/21/13 at 5:59 PM with Van Driver #2 revealed Resident #64 had never unfastened his lap/shoulder belt before but she recalled him being very agitated saying his bottom was burning.</p> <p>Interview with the DON on 03/21/13 at 2:52 PM revealed Van Driver #2 told her she left the dialysis parking lot, didn't know if he hit the button of the seat belt or if he slid out from under the lap</p>	F 323	<p>The results of the transportation audit tool will be reviewed by the administrator any time a concern is identified. This includes any need for guidance or errors noted when completing the transportation audit tool. The audit tool was completed on 6 of 8 transportation staff on 3/23/13. The remaining 2 transportation staff members will be audited upon return to the facility. These 2 transportation staff members will not be permitted to drive until all education, transportation audit tool and return demonstration have been satisfactory completed.</p> <p>All concerns/problems will be presented at the monthly QA meetings for committee input and recommendations. If any concerns or problems are identified system changes will take place. The transportation observation tool will remain as part of the monthly QA program on an ongoing basis.</p> <p><i>The transportation audit tool and return demonstration have been satisfactorily completed with the remaining drivers (1) the 2<sup>nd</sup> driver will no longer transport resident per her request.</i></p>	3/28/13
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F 323	<p>Continued From page 56</p> <p>belt. She just told the DON he slid to the floor. The DON stated she asked the van driver if the shoulder or lap belt were in place and she didn't think so and she stated she was afraid to get her hands soiled. The DON stated she looked at it as a mistake or misjudgement on the part of the van driver. The van driver told the DON the resident was rushing her.</p> <p>Review of the statement dated 02/06/13 at 12:45 PM taken by the DON from Resident #64 revealed she asked if he could tell what happened and the resident stated "I just slid out of chair real slow like when we stopped, we were barely moving." The statement continued stating he was asked if he remembered having his seat belt on when the van started at dialysis clinic and he stated "I don't think so, I know chair wasn't moving because I had to go really bad and I was wiggling around trying to hold it in and chair wouldn't budge." Then the statement indicated he was asked if he pushed any button or straps and he stated "I don't think so." The written follow up interview with Resident #64 on 02/12/13 at 11:00 AM by the DON stated "Explained we thought he had slid out of w/c (wheelchair) because seat belt not attached and he was "wiggling" in chair and he stated, "that's probably right, cause I knew I had to go real, real bad."</p> <p>On 03/21/13 at 9:17 AM, Resident #64 was interviewed. He stated the van stopped and he slid out of the chair but did not get hurt. He stated he was not strapped in by the shoulder or lap belt. He stated he never thought about it at the time. He stated this was not a big deal as the dialysis center was very close to the facility. He stated normally he is always secured with lap and</p>	F 323		

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F 323	<p>Continued From page 57 shoulder belts.</p> <p>On 03/21/13 at 2:52 PM, the DON stated during her interview with the resident, he admitted he was rushing Van Driver #2 to hurry.</p> <p>Nurse #4 was interviewed on 3/22/13 at 8:38 AM. She stated she was called to go to the van on the morning of 02/06/13 to assess Resident #64. She stated when she entered the van, the resident was sitting on his bottom on the van floor in front of the wheelchair. She could not recall how the wheelchair was secured and she would not have looked at that aspect of the situation. Resident #64 stated he hit his head but assessment revealed no evidence of bumps. He was incontinent and stated he just wanted to be cleaned up and returned to dialysis. Per Nurse #4 Resident #64 did not know what happened and the van driver told Nurse #4 she was talking to the resident and then turned around and saw him on the floor.</p>	F 323		
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	<p>Interview with the Administrator on 03/21/13 at 1:23 PM revealed when he arrived at the facility, he had Van Driver #2 demonstrate for him how she secured the wheelchair. She demonstrated securement of the wheelchair properly. The Administrator stated she could not recall if the lap or shoulder belts were on and the resident could not recall if the lap or shoulder belts were on. The administrator described Resident #64 as being very alert and oriented. Per the Administrator he could not confirm the van driver did not use the lap or shoulder belts on Resident #64. The administrator further stated an action plan was devised and implemented on 02/06/13 and 02/07/13 as follows:</p>			
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F 323	<p>Continued From page 58</p> <ul style="list-style-type: none"> <li>*An investigation was initiated;</li> <li>*The Van and Resident #64's wheelchair was inspected and no problems or concerns were noted;</li> <li>*Van Driver #2 was suspended, drug tested, and put on a performance improvement plan for "failure to put seat belt straps on resident during transport" ;</li> <li>*3 new videos were obtained on 02/06/13 for educational purposes, one relating to securement of wheelchair bound residents;</li> <li>*All transportation staff watched the videos, took a quiz, and were visually observed and noted competent on attaching "Tie Down" straps and attaching seat belts properly; and</li> <li>*Monthly observation audits already in place after a van incident in August 2012 regarding wheelchair securement remained the same and continued monthly.</li> </ul> <p>The video for the Sure Lok securement system was observed on 03/22/13 at 2:00 PM by a surveyor, the Administrator and a corporate staff member. The video identified the different tract fittings in the van floor and the different straps available. The Administrator identified the van floor fittings and straps used by the facility. The video indicated the wheelchair should face forward, the wheels should be between the floor tracks, the wheelchair brakes should be locked, the rear strap should be attached then the front straps and tightened. The Video noted the straps should form a 45 degree angle when attached to the wheelchair and once secured, the wheelchair should move no greater than 2 inches side to side or front to back. In regards to securing the wheelchair occupant, the video revealed the lap belt should be over the pelvic zone and the snap</p>	F 323		

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F 323	<p>Continued From page 59</p> <p>hook attached to the D ring in back on the floor. The shoulder belt should be over the shoulder and attached to the lap belt. There was no manual or written guide to accompany this video.</p> <p>Review of the video, observations of staff securing a wheelchair bound resident in the van, and interviews with staff revealed that the action plan was ineffective as follows:</p> <p>On 03/22/13 at 6:15 AM, Van Driver #2 was observed securing a resident sitting in the wheelchair into the facility van. The Administrator was also present as this was one of the demonstrational checks for the quality assurance plan. The wheelchair was secured by straps to the bar under the resident's wheelchair under the seat via 2 straps connecting to floor in the front of the wheelchair and 2 straps connecting to the floor behind the wheelchair. The Administrator stated at this time he thought the video showed the straps should be at seat level but he was fearful of the wheelchair-frame's strength at this point due to some being made of plastic. Van Driver #2 then placed the lap belt across the upper portion of his stomach and secured the two ends to the floor behind the wheelchair. She proceeded to apply the shoulder strap and connected it to the clip on the lap belt. The shoulder belt was then positioned over his shoulder and ran down the front of his chest to the middle of his stomach. She then tightened it. Once completed, the Administrator provided instructions on the position of the lap belt, removed the lap belt and reapplied it down towards the resident's hip, and moved the lap belt around ensuring the clip to which the shoulder belt attached resulted in the shoulder strap was</p>	F 323			

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F 323	<p>Continued From page 60</p> <p>across his chest and connected closer to his right hip. The administrator then tightened the back straps of the wheelchair tighter, removing slack.</p> <p>On 03/22 at 10:02 AM the Administrator stated Van Driver #2 was in a hurry this morning and normally she had the lap and shoulder belts correctly applied. He stated he had to provide additional instruction this morning and he would need to make more frequent observations of her in the future.</p> <p>On 03/22/13 at 3:15 PM, the Administrator and the maintenance director each demonstrated in the van how they secured wheelchairs differently in the van by placing the straps at different locations on the wheelchair. The floor fittings and straps used were those identified by the administrator during the video. The Administrator placed the straps on the frame under the wheelchair and the maintenance director secured the front straps to the arm rests close to the seat of the wheelchair. Neither were at a 45 degree angle. The Administrator stated there was not an exact way to secure the wheelchair.</p> <p>The Administrator was informed of Immediate Jeopardy on 03/22/13 at 10:39 PM for Resident #149 and Resident #64.</p> <p>A Credible Allegation of Compliance was accepted on 03/23/13 at 4:50 PM as follows:</p> <p>Credible Allegation of Compliance: Affected Resident Corrective Action Resident #64 was admitted on 10/4/12 with diagnosis including end stage renal disease, high blood pressure and on hemodialysis. On 2/6/13</p>	F 323			

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F 323	<p>Continued From page 61</p> <p>while being transported in the facility van from dialysis when resident became uncomfortable and shifting around in the wheelchair. When the driver stopped at the stop sign the resident slid from the wheelchair to the floor and bumped his head. Investigation by the administrator and DON revealed seatbelt was unbuckled. Neurochecks were initiated and were in normal limits. Resident had no complaints of pain from incident.</p> <p>Corrected Action Accomplished for Residents With The Potential To be AFFECTED All residents who are transported in the facility van have the potential to be affected. Corrective action for event on 2/6/13: On 2/6/13, Van inspected for proper mechanical functioning of resident wheelchair securement system including floor tracks, tie downs, shoulder straps and lift mechanism was done by administrator and maintenance director and no mechanical problems were found. Specific driver in 2/6/13 incident was suspended from driving on 2/6/13 by the administrator until the investigation was completed. A drug test of the employee by staff development coordinator on 2/6/13 was negative. All transportation staff were given a written quiz "driving safety" which included information on seatbelts on 2/6/13-2/7/13. A return demonstration of the wheelchair securement and in-servicing was completed on 2/6/13-2/7/13.</p> <p>Measures/Systemic Changes Corrective action for event on 2/6/13: The New transportation safety program implemented on 2/6/13 included new videos, "Doing it right," "Driving Safely," and "Braun Lift". Transportation observation audit tool was utilized</p>	F 323			

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F 323	Continued From page 62 to include the following: Were proper techniques used to place the resident into the van, were proper tech, used to secure resident i.e. attach seat belts, ties downs, etc., were proper techniques used to operate hydraulic van lift, were proper techniques used to unload the resident from the van, is there documentation the employee has been educated regarding proper use of the equipment/van. All transportation staff was educated and observed an additional return demonstration of transportation observation audit tool. Transportation staff was randomly audited by the administrator and maintenance director monthly. On 3/22/13 all in-house facility resident transports were suspended. The transportation observation tool was revised on 3/22/13 to include the following additions: Are tie downs observed at approximately 45 degrees? Are the tie downs secured at each corner of the wheelchair? The transportation staff was re-educated on transportation policy and procedures to include the videos, "Doing it right," "Driving Safely," and "Braun Lift" and a completed revised transportation observation tool and return demonstration of wheelchair securement in the van. The transportation staff will not be allowed to transport any resident until all training has been completed. The audit tool was completed on 6 of 8 transportation staff on 3/23/13. The remaining 2 transportation staff members will be audited upon return to the facility. These 2 transportation staff members will not be permitted to drive until all education, transportation audit tool and return demonstration has been satisfactory completed.	F 323			

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F 323	<p>Continued From page 63</p> <p>The transportation observation tool involving multiple drivers will be done five times a week for two weeks by the administrator or maintenance director.</p> <p>Then, three times a week for four weeks by the administrator or maintenance director.</p> <p>Then, weekly for three months by the administrator or maintenance director.</p> <p>QA</p> <p>The revised transportation audit tool includes:</p> <p>Were proper techniques used to place the resident into the van?</p> <p>Were proper techniques, used to secure resident i.e. attach seat belts, ties downs, etc.?</p> <p>Were proper techniques used to operate hydraulic van lift?</p> <p>Were proper techniques used to unload the resident from the van?</p> <p>Is there documentation the employee has been educated regarding proper use of the equipment/van?</p> <p>Are tie-downs observed at approximately 45 degrees?</p> <p>Are the tie downs secured at each corner of the wheelchair?</p> <p>The transportation observation tool involving multiple drivers will be done five times a week for two weeks by the administrator or maintenance director.</p> <p>Then, three times a week for four weeks by the administrator or maintenance director.</p> <p>Then, weekly for three months by the administrator or maintenance director.</p> <p>The results of the transportation audit tool will be reviewed by the administrator any time a concern is identified. This includes any need for guidance or errors noted when completing the</p>	F 323		
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F 323	Continued From page 64 transportation audit tool. All concerns/problems will be presented at the monthly QA meetings for committee input and recommendations. If any concerns or problems are identified system changes will take place. The transportation observation tool will remain as part of the monthly QA program on an ongoing basis.  Immediate Jeopardy was lifted on 03/23/13 at 4:50 PM. The facility provided evidence of additional inservice training for all transportation staff. Interviews and observations of transportation staff securing wheelchair bound residents in the facility van per the video were completed. Interviews of transportation staff revealed each staff had been securing the wheelchairs differently and now they were aware of the proper technique for safe transport.	F 323		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.  A State or the Secretary may not require	F 520	<b>F 520</b> QUALITY ASSURANCE COMMITTEE  1. AFFECTED RESIDENT CORRECTIVE ACTION  Resident #114 was admitted to the facility on 9/24/12 with diagnosis that included chronic kidney disease, high blood pressure, stroke and dementia. The resident had a Do Not Resuscitate (DNR) order dated 9/24/12.  On 12/27/12 at 8:00pm Resident #114 stopped breathing and Cardiopulmonary Resuscitation (CPR) was started. The CPR was stopped after the resident's chart was checked and the DNR was noted.	4/17/13

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F 520	<p>Continued From page 65</p> <p>disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff interviews and resident interviews, the facility failed to develop and implement plans of action after 1 of 2 sampled residents did not have their choices for advanced directives for code status honored (Resident #114).</p> <p>The findings included:</p> <p>Resident #114 was admitted on 09/24/12 with diagnoses that included heart disease, high blood pressure, dementia, kidney disease and a stroke with left-sided weakness. The resident expired on 12/27/12 at 8:05 PM.</p> <p>A review of the admission Minimum Data Set (MDS) dated 09/24/12 indicated Resident #114 had impairment in short term and long term memory and was moderately impaired in cognition for daily decision making and required extensive assistance from staff for activities of daily living.</p> <p>A review of a yellow form with a red stop sign in the top left hand corner indicated Do Not Resuscitate (DNR) Order dated 09/24/12 with no</p>	F 520	<p>2. CORRECTIVE ACTION ACCOMPLISHED FOR ALL RESIDENTS WITH THE POTENTIAL TO BE AFFECTED</p> <p>All staff will be in-serviced by the staff development coordinator starting 3/23/13 in regards to the Quality Assurance Committee and Program. This in-service objective is:</p> <ul style="list-style-type: none"> <li>The facility staff will understand the purpose of the QA program: to provide means for a resident care or safety issues to be resolved.</li> <li>Staff will know how the QA program works and who to contact with any actual or potential issues that are identified.</li> <li>Staff will understand how the QA program monitors and develops the plan to address any potential or actual problem.</li> <li>Staff will understand how the QA committee monitors the potential or actual problem identified.</li> <li>The staff will understand who and how to contact/discuss any potential or actual problem so that the QA committee will follow up.</li> </ul> <p>3. MEASURE/SYSTEMIC CHANGES</p> <p>The QA policy was reviewed on 3/23/13, this policy states the facility shall develop, implement, and maintain an ongoing</p>	
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F 520	<p>Continued From page 66 expiration date.</p> <p>A review of a document titled "Acknowledgement of Receipt of Advanced Directives Information" dated 09/24/12 had an "x" next to "provided a copy to the facility" for DNR status and was signed by a family member.</p> <p>A review of a Physician's Progress Note with a date of service of 09/25/12 indicated Code Status: Do Not Attempt Resuscitation (DNR/No CPR).</p> <p>A review of a Palliative Care Progress Note dated 09/26/12 indicated Resident #114 remains a DO NOT RESUSCITATE.</p> <p>A review of a physician's order dated 09/26/12 indicated DNR and nurse may pronounce expired and release body to funeral home of choice.</p> <p>A review of a nurse's note dated 12/27/12 at 8:00 PM indicated a Nurse Aide (NA) was with Resident #114 giving incontinence care and called a nurse to the room because the resident was not breathing right. The notes revealed Resident #114 had shallow breathing and then stopped breathing and CPR was started. The notes further indicated Resident #114's chart was checked and the DNR order was found and CPR was stopped at 8:05 PM.</p> <p>A review of a Coroner/Medical Examiner report dated 12/27/12 indicated in a section titled "Events that have taken place" a NA noted the resident was having shallow respirations then not breathing. The report further indicated a nurse arrived and the resident had no pulse and was</p>	F 520	<p>program designed to monitor and evaluate the quality of resident care, pursue methods to improve quality care, and to resolve identified problems.</p> <p>All staff will be in-serviced by the staff development coordinator starting 3/23/13 in regards to the Quality Assurance Committee and Program. This in-service objective is:</p> <ul style="list-style-type: none"> <li>The facility staff will understand the purpose of the QA program: to provide means for a resident care or safety issues to be resolved.</li> <li>Staff will know how the QA program works and who to contact with any actual or potential issues that are identified.</li> <li>Staff will understand how the QA program monitors and develops the plan to address any potential or actual problem.</li> <li>Staff will understand how the QA committee monitors the potential or actual problem identified.</li> <li>The staff will understand who and how to contact/discuss any potential or actual problem so that the QA committee will follow up.</li> </ul> <p>The Staff Awareness of QA Program audit was developed on 3/23/13 to verify staff awareness of QA program. The audit will:</p>	
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F 520	<p>Continued From page 67</p> <p>not breathing and CPR was started. The report revealed the nursing staff found a DNR order and CPR was discontinued.</p> <p>A review of Administrative Nurse's Meeting minutes dated 01/04/13 indicated there were no notes regarding Resident #114.</p> <p>During an interview on 03/21/13 at 4:37 PM Nurse #3 stated a NA called her to Resident #114's room because the resident wasn't breathing right. She explained she started to assess Resident #114 and the resident stopped breathing so she tried to reposition the resident and gave the resident a sternal rub and described it as a firm and vigorous rub of the resident's chest to stimulate the resident to breathe but she did not start breathing and she then gave Resident #114 rescue breathing with an ambu bag. She stated she had started to begin chest compressions when someone brought her the resident's chart and she saw the yellow stop sign form and she stopped everything. She further stated she then called the resident's family, the physician and the Director of Nursing and told them Resident #114 had expired. She stated no one from administration called her or talked to her about Resident #114 and she was not aware that anything changed to verify that the code status was correct on resident's charts.</p> <p>During an interview on 03/21/13 at 5:03 PM with the Director of Nursing (DON) stated she did not remember that CPR was initiated with Resident #114 and did not remember if Nurse #3 called her on 12/27/12. She stated Nurse #3 should not have started rescue breathing with an ambu bag or performed the sternal rub until she checked</p>	F 520	<ul style="list-style-type: none"> <li>• Monitor staff awareness of the QA program and the purpose of the program.</li> <li>• Monitor that the facility staff will understand the purpose of the QA program: to provide means for a resident care or safety issues to be resolved.</li> <li>• Monitor if staff know how the QA program works and who to contact with any actual or potential issues that are identified.</li> <li>• Monitor if staff understands how the QA program monitors and develops the plan to address any potential or actual problem.</li> <li>• Monitor if staff understands how the QA committee monitors the potential or actual problem identified.</li> <li>• Monitor if staff understands who and how to contact/discuss any potential or actual problem so that the QA committee will follow up.</li> </ul> <p>The Staff Awareness of QA Program audit will be started on 3/23/13 with all staff to include new staff on orientation and staff on leave to be audited by staff development coordinator and administrative RN upon return to the facility.</p>	

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NAME OF PROVIDER OR SUPPLIER  PEAK RESOURCES - SHELBY	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET, BOX 2287 SHELBY, NC 28150
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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
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F 520	<p>Continued From page 68</p> <p>the chart and determined what the resident's code status was.</p> <p>During an interview on 03/22/13 at 5:38 PM the Administrator confirmed the QA Committee met monthly and verified the QA committee met on 03/27/13 at noon and there was no discussion about Resident #114's code status. He stated the weekly Administrative Nurse's meeting was considered to be a sub-committee of the QA committee and he expected that the events surrounding Resident #114's code should have been discussed in the weekly nurses meeting and then should have been brought to the QA committee. He stated that the QA committee had discussed advanced directives in past QA meetings but there was no specific information discussed regarding Resident #114 and the chart audits that had been done had not been presented to the QA committee.</p> <p>A review of admission audits on 03/23/13 at 11:00-AM revealed 202 total audit sheets with columns that listed each document that was to be filed in each resident's chart and whether the information was complete in the chart, not complete, the responsible department, problems and date of correction. The list of documents included advanced directives and DNR and Full Code forms. A further review of the audits revealed 11 audit sheets that were incomplete and 3 of these audits did not have documentation regarding advanced directives and/or DNR checked as complete as follows: 09/24/12 Acknowledgement of Advanced Directives and DNR were not checked as complete. 01/28/13 Acknowledgement of Advanced</p>	F 520	<p>Then 20% of staff randomly weekly for 4 weeks by the staff development coordinator and administrative RN. Then 20% of staff randomly biweekly for 4 weeks by the staff development coordinator and administrative RN. Then 20% of staff randomly monthly for 3 months by the staff development coordinator and administrative RN.</p> <p>4. QA</p> <p>Results of the Staff Awareness of QA Program audit will be reviewed, analyzed and discussed by the QA committee monthly at the QA meeting for the committee input and recommendation. If any concerns or problems are identified system changes will take place. The QA committee will monitor monthly for no less than 3 months. The Staff Awareness of QA Program audit will remain as part of the monthly QA program on an ongoing basis.</p> <p>QA committee minutes will be reviewed monthly by a representative of Peak Resources Corporate Office for 6 months.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 520	<p>Continued From page 69</p> <p>Directives was not checked as complete. 02/19/13 Acknowledgement of Advanced Directives and DNR were not checked as complete.</p> <p>During a phone interview on 03/23/13 at 11:45 AM the Medical Record Information Clerk stated she started the admission audit when a resident was admitted. She explained she would complete the first part of the form the same day or the next day if the resident was admitted late in the afternoon. She stated she usually went to the department and talked with the responsible person to let them know that their forms were not complete in the chart and then checks the chart again in a couple days to see if its been completed. She explained she communicated to the responsible party either verbally, or by a note or on the audit form. She stated she kept the forms in a notebook but the findings were not tallied and the information was not passed on to anyone else for review or discussion.</p>	F 520	<p>The new audit tool has not identified Any issues regarding staff awareness of the QA program focus.</p>	4/17/13
	<p>During a follow up interview on 03/23/13 at 5:05 PM the DON verified there was not a discussion or evaluation of the occurrence of Resident #114's code. She further verified there were no notes in the weekly nursing meeting minutes dated 01/04/13 because it was not discussed in the meeting.</p> <p>During an interview on 03/21/13 at 5:03 PM the Director of Nursing (DON) stated she expected nursing staff to honor a resident's code status and if the resident was a DNR then CPR should not be started and 2 nurses should confirm that the resident was not breathing and had no pulse and then call the doctor, family and funeral home.</p>			

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F 520	Continued From page 70 She further confirmed that there was no discussion of Resident #114's code in the weekly Administrative Meeting dated 01/04/13 and confirmed there was no documentation in the meeting minutes. She explained that it was their usual process when there was an incident it should be discussed in the weekly meeting and action plans developed with interventions put in place to monitor. She also stated she did not remember any discussion at the monthly QA meeting of Resident #114's code status.	F 520			