

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

PRINTED: 08/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345246	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/20/2013
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NAME OF PROVIDER OR SUPPLIER  CAMELOT MANOR NURSING CARE FAC	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET ST GRANITE FALLS, NC 28630
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F 000	<p>INITIAL COMMENTS</p> <p>483.25 (F309) at J Immediate Jeopardy began on 06/19/13 when Resident #1 vomited dark colored liquid. Immediate jeopardy was removed on 07/20/13 at 5:15 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 ensure monitoring of systems put into place are effective and completion of employee training.</p> <p>483.25 (F323) at J Immediate Jeopardy began on 07/14/13 when Resident #13 eloped from the facility without staff's knowledge that he was outside without supervision. Immediate jeopardy was removed on 07/20/13 when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level of D (an isolated deficiency, no actual arm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put in place and completion of employee training.</p> <p>483.25 (F-329) at J Immediate Jeopardy began on 06/19/13 when Resident #1 vomited dark colored liquid. Immediate jeopardy was removed on 07/20/13 at 5:15 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</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE RN Don (X6) DATE 8/14/13

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 30 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Original Signature Date: 8/9/13



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F 000	Continued From page 1 (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective and completion of employee training.	F 000		
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 physician and staff interviews, the facility failed to identify and assess the need for medical intervention for a resident who was vomiting dark brown liquid, had a nosebleed and was on daily dosages of coumadin (blood thinner) in 1 of 10 residents on coumadin therapy. (Resident #1).  Immediate Jeopardy began on 06/19/13 when Resident #1 vomited dark colored liquid. Immediate jeopardy was removed on 07/20/13 at 5:15 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 ensure monitoring of systems put into place are effective and	F 309	To ensure that each resident receive and the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with their comprehensive assessment and plan of care for compliance with Tag F309 483.25 "Provide Care/Services for highest well being" the following plan of action was implemented:  1. Nurse #1 who failed to notify the MD of resident's nosebleed was terminated. 7/23/2013 2. Charge Nurse that failed to assess and call MD regarding resident's nosebleed was counseled in writing. 7/24/2013 3. The facility QI Nurse completed an audit of all residents who were currently on Coumadin. 7/19/2013 4. Coumadin audits will continue weekly on an ongoing basis by the QI Nurse and/or Charge Nurse 8/31/2013 5. Coumadin audit results will be discussed in the inter-disciplinary meeting each Thursday. 8/31/2013 6. Any educational opportunities identified will be immediately addressed by the QI Nurse and/or Charge Nurse. 8/31/2013 7. Report on the Coumadin audit results was presented to the QAPI Committee. 7/25/2013	



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F 309	<p>Continued From page 3</p> <p>a Prothrombin time (PT)/ International Normalized ratio (INR) with a collect date of 05/29/13, received date of 05/30/13 and a reported date of 05/31/13 indicated (PT) 23.9 (High) with a reference range of 11.5 to 14.1 seconds and (INR) 2.33 (High) with a reference range of 0.89 -1.16. (The PT/INR blood test results provide information for the physician to titrate the dosage of Coumadin).</p> <p>A review of a MAR dated 06/01/13 through 06/20/13 indicated Resident #1 received coumadin daily by mouth at 5:00 PM.</p> <p>A review of a nurse's note dated 06/19/13 at 10:12 AM and written by Nurse #4 indicated Resident #1 vomited small amount of dark liquid this morning.</p> <p>During an interview on 07/19/13 at 5:24 PM Nurse #3 who was also a charge nurse during the 7:00 AM to 7:00 PM shift explained he was told Resident #1 vomited a yellowish colored liquid but did not remember being told about dark colored vomiting. He stated he was aware Resident #1 had a history of stomach bleeding and if staff had reported dark colored vomiting it would have gotten his attention.</p> <p>A review of a treatment sheet from the dialysis center dated 06/20/13 in a section titled Pre - Dialysis "other comments" revealed Resident #1 's nurse from the facility called and stated Resident #1 vomited today and yesterday and vomit was dark but not coffee ground consistency and upon arrival at dialysis Resident #1 stated he had been vomiting for 3 days. A section titled "Treatment Data" indicated Resident #1 had dialysis started on 06/20/13 at 10:25 AM and</p>	F 309	<p>15. This practice is continuing and is monitored by the licensed nurse on a daily basis.</p> <p>16. Any deviation from this system will be reported directly to the Charge Nurse and will be reported to the Director of Nursing</p> <p>17. Director of Nursing will implement changes as needed for the system to operate effectively.</p> <p>18. DON will report effectiveness of system in the QAPI Committee and will report quarterly until full compliance has been consistently maintained.</p> <p>19. On 7/19/2012 the Administrative Nursing Staff began to in-service all nursing staff on the administration of Coumadin</p> <ul style="list-style-type: none"> <li>➤ Nurses were not permitted to work until they received the inservice training</li> </ul> <p>Contents of this inservice included:</p> <ul style="list-style-type: none"> <li>➤ New Coumadin Log;</li> <li>➤ PT/INR results and how Coumadin affects coagulation times;</li> <li>➤ Nurses only to give Coumadin;</li> <li>➤ The E-MAR software that alerts the medication aide that the nursed has to administer the Coumadin;</li> <li>➤ Medication Aides trained on the new procedure of only nurses to administer Coumadin;</li> <li>➤ New parameters set on E-MAR software for Coumadin administration;</li> <li>➤ Signs and symptoms of bleeding, abnormal INR results and when to notify physician;</li> </ul>	<p>8/31/2013</p> <p>8/31/2013</p> <p>8/31/2013</p> <p>8/31/2013</p> <p>7/20/2013</p> <p>7/20/2013</p>

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F 309	<p>Continued From page 4 completed it at 1:56 PM. The notes revealed Resident #1 was alert, denied complaints and had no nausea or vomiting. A section titled Post - Dialysis indicated no new complaints or observations developed during dialysis and Resident #1 was discharged back to the facility.</p> <p>During a phone interview on 07/19/13 at 9:22 AM with a dialysis nurse she explained Resident #1 received dialysis treatments on Monday, Wednesday and Friday of each week. She further explained Resident #1 was seen in the dialysis center on Thursday 06/20/13 and received a treatment because he missed his dialysis treatment on Wednesday 06/19/13 because the facility had reported Resident #1 was vomiting a dark brown liquid. She stated Resident #1 stated he had been vomiting for 3 days and it was a dark brown cola color. She further stated a lab test for a hemoglobin was drawn on 06/20/12 and the results were 12.0 (Low) with a reference range 14.0-18.0 but there was no PT/INR drawn because he was not due for his monthly PT/INR until the end of June 2013 and he did not have symptoms at the dialysis center to cause them to question what his PT/INR results were. She explained he was sent back to the facility mid afternoon on 06/20/13 and confirmed Resident #1 did not have vomiting or a nosebleed while in the dialysis center.</p> <p>A review of a nurse's note dated 06/20/13 at 7:39 PM and written by Nurse #2 indicated Resident #1 continued on coumadin 5 mg. by mouth. The notes further indicated Resident #1 went to dialysis and labs were drawn; Resident #1 was noted to have a nose bleed from right nostril; Nurse #2 packed nostril with rolled gauze and expressed to resident to leave in place till</p>	F 309	<p>20. New Tool Developed:</p> <ul style="list-style-type: none"> <li>➤ Hall Nurse Daily Coumadin Log reviewed;</li> <li>➤ Signs and symptoms of bleeding noted at the bottom of the new Hall Nurse Daily Coumadin Log.</li> </ul> <p>21. Education continues for new nursing employee during orientation, staff meetings and hall team meetings on signs and symptoms of bleeding related to Coumadin dosing and expectation set by the Director of Nursing that communication of any abnormal signs and symptoms of bleeding communicated to the MD immediately by the Charge Nurse</p> <p>22. Charge Nurse monitors PT/INR's on a daily basis and implements adjustment to Coumadin as ordered.</p> <p>23. Hall nurses to document daily in nursing notes;</p> <ul style="list-style-type: none"> <li>➤ The daily dose of Coumadin;</li> <li>➤ The last PT/INR;</li> <li>➤ The diagnosis for Coumadin</li> <li>➤ Next scheduled PT/INR date.</li> </ul> <p>24. Director of Nursing reviews all orders in the daily morning nursing team meeting to ensure accuracy.</p> <p>25. Charge Nurse will review Coumadin log in daily morning nursing team meetings to ensure new orders for Coumadin changes are implemented and new orders for labs are being processed appropriately</p>	<p>8/31/2013</p> <p>8/31/2013</p> <p>8/31/2013</p> <p>8/31/2013</p> <p>8/31/2013</p> <p>8/31/2013</p>

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F 309	Continued From page 5 tomorrow. The notes also indicated to place ice pack to bridge of nose for 3 minutes; noted to stop bleeding. The notes revealed vital signs were temperature 98.6 degrees Fahrenheit, Pulse 98, Respirations 16, blood pressure 120/76 and oxygen saturation percentage was 97.  During a phone interview on 07/19/13 at 9:56 AM Nurse #2 verified she worked from 7:00 AM to 7:00 PM and was assigned as Resident #1's nurse on 06/20/13. She explained Resident #1 had vomited a dark brown liquid and she was concerned because she knew Resident #1 had a history of stomach bleeding. She stated Resident #1 went to dialysis that morning and she thought they would send him to the hospital but he came back to the facility that afternoon. Nurse #2 explained Nurse Aide (NA) #4 called her to Resident #1's room and he was sitting in his wheelchair and was bleeding from his nose. She stated her first response was to stop the bleeding so she put ice on the top of his nose and rolled up gauze to pack in his nose. She further stated she told Resident #1 to leave the packing in place until the next day. She explained Resident #1 was very pale and she called the dialysis center to ask them if they checked Resident #1's PT/INR and was told they did not because he was not due for his monthly PT/INR. Nurse #2 stated she talked to Nurse #3 who was the charge nurse about Resident #1 and verified she did not call the facility physician because that was not her call to make since the charge nurse usually called the physician. She explained Resident #1 pulled the gauze out of his nose before she finished her shift at 7:00 PM. She stated she got another clean piece of gauze and rolled it up and put it in Resident #1's nose because she was concerned he would continue to have bleeding during the	F 309	26. The Facility QI Nurse will complete weekly audits of Coumadin log which includes: ➤ Labs and dates; ➤ Diagnosis for Coumadin ➤ Coumadin dose and changes 27. The QI nurse will audit staff response time to abnormal labs and/or signs and symptoms of abnormal bleeding and will report weekly audits in the morning nursing team meetings on Thursdays of each week. 28. Results of the QI Nurse Coumadin Audit which includes the staff's response to ensure well-being of each resident was presented to the facility's QA/PI Committees and quarterly reports to the Committee will continue until compliance is maintained. 29. Lab reports to include Coumadin Audit findings will be presented to the QA/PI Committee on a quarterly basis.	8/31/2013  8/31/2013  7/25/2013  8/31/2013	

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F 309	<p>Continued From page 6</p> <p>night. She explained she reported Resident #1's nosebleed during shift report at 7:00 PM to the night shift nurse.</p> <p>During an interview on 07/19/13 at 2:53 PM with NA #4 she verified she worked on the 3:00 PM to 11:00 PM shift on 06/20/13 and was assigned to Resident #1. She explained Resident #1 came back to the facility from dialysis between 3:30 and 4:00 PM on 06/20/13. She stated she went to Resident #1's room about 10 minutes after he arrived at the facility because his call light was on and when she walked in his room she saw his nose was "gushing blood." She explained bright red blood was running out of his nose, was on his face and in his beard and was all over his fingertips. She stated Resident #1 was very pale and weak and she went and told Nurse #2 and the nurse came to Resident #1's room.</p> <p>During an interview on 07/19/13 at 3:14 PM with transport aide (TA #2) he explained Resident #1 went to the dialysis center on Monday, Wednesday and Friday of each week and they usually left the facility around 9:15 AM. He stated he took Resident #1 to dialysis on Thursday morning 06/20/13 because he had missed his appointment on 06/19/13 and picked him up that afternoon. He stated when he got Resident #1 back to the facility he took the resident to his room. He confirmed Resident #1 did not have any vomiting or nosebleed when he transported him on 06/20/13. He further stated Resident #1 looked weak and pale and was very quiet during the transport back to the facility.</p> <p>During an interview on 07/19/13 at 5:24 PM with Nurse #3 he verified he worked 7:00 AM to 7:00 PM on 06/20/13 and was assigned as the charge</p>	F 309			

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F 309	<p>Continued From page 7</p> <p>nurse. He explained when Resident #1 returned from dialysis Nurse #2 reported he had bleeding from his nose and was vomiting dark brown liquid. Nurse #3 stated he looked at Resident #1 but did not assess him. He explained Resident #1 had a communication sheet from the dialysis center but it didn't ' t have any notes about bleeding or labs. He stated he should have followed through and called the facility physician or physician's assistant to find out what they needed to do but he didn't recognize the seriousness of what was going on.</p> <p>A review of a nurse's note dated 06/21/13 at 12:29 AM indicated Resident #1 continued coumadin 5 mg. as ordered. The notes also indicated nose had stopped bleeding at this time and right nostril was packed with gauze and there were no complaints of pain or discomfort and no acute distress.</p> <p>During an interview on 07/19/13 at 3:31 PM with NA #5 she explained she worked on Friday 06/21/13 on the 7:00 AM to 3:00 PM. She stated when she went in to get Resident #1 up she saw one nostril plugged up with gauze but the gauze was out of the other nostril and it was not bleeding. She further stated when she got Resident #1 up on Friday 06/21/13 he said he did not feel well, was having trouble standing and said he needed help and that wasn't normal for him because usually he stood and pivoted without assistance. She explained she told Nurse #2 that Resident #1 was not doing well and was told by Nurse #2 that Resident #1 was losing blood. She stated she cleaned and dressed Resident #1 and he went to dialysis.</p> <p>During an interview on 07/19/13 at 9:56 AM</p>	F 309			



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F 309	<p>Continued From page 8</p> <p>Nurse #2 stated when she returned to work on 06/21/13 Resident #1 looked worse and his skin color was paler but he was alert and responded to her. She further stated she talked with Nurse #1 who was also a charge nurse about Resident #1 and was told Nurse #1 had talked to the dialysis center. She explained Resident #1 went to the dialysis center again that morning and was sent to the hospital from the dialysis center.</p> <p>During a phone interview on 07/19/13 at 9:22 AM a dialysis nurse stated Resident #1 came to the dialysis center on Friday morning 06/21/13 but they did not put him on a dialysis machine because he was lethargic, had labored breathing and was slow to respond to dialysis staff 's questions. She explained Resident #1 requested to be sent to the ER and confirmed they did not draw any labs at the dialysis center because they knew labs would be drawn in the ER.</p> <p>During an interview on 07/19/13 at 4:35 PM the Director of Nursing (DON) stated she was not aware of Resident #1's changes in condition with dark colored vomiting or nosebleed. She stated it was her expectation for nursing staff to assess and monitor residents for changes in condition and obtain whatever medical intervention was needed for the resident.</p> <p>During an interview on 07/19/13 at 4:46 PM the facility physician stated it was his expectation for nursing staff to monitor and assess residents for changes in condition and to communicate with the medical providers.</p> <p>During an interview on 07/19/13 at 5:51 PM with Nurse #1 she verified she was the charge nurse on Friday 06/21/13. She explained Nurse #2 told</p>	F 309		

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F 309	<p>Continued From page 9</p> <p>her that morning Resident #1 was vomiting a dark brown cola colored liquid and had a nose bleed the day before. She stated Resident #1 was sent to dialysis because she felt a physician would see the resident at the dialysis center but later that day the dialysis center called her and told her Resident #1 was sent to the hospital.</p> <p>A review of a nurse's note dated 06/21/13 at 10:45 AM indicated dialysis center called and reported Resident #1 had been sent to the hospital for evaluation and treatment.</p> <p>A review of a nurse's note dated 06/21/13 at 5:44 PM indicated a call was received from a physician at the hospital that Resident #1 had been admitted to the intensive care unit.</p> <p>A review of a nurse's note dated 06/21/13 at 6:44 PM titled "addendum" indicated a physician from the hospital called the facility and reported that Resident #1's blood was "too thin" and Resident #1 "was not in good shape."</p> <p>A review of a hospital history and physical dated 06/21/13 indicated Resident #1 was to have dialysis today but was vomiting dark brown material and was sent to the emergency room (ER) for evaluation. The notes indicated Resident #1 was chronically ill appearing, poorly unresponsive with respiratory distress and a PT/INR was drawn and the results revealed his blood was not coagulable (was not clotting). The notes revealed Resident #1 was admitted to the intensive care unit, received 2 units of fresh frozen plasma and intravenous Vitamin K.</p> <p>A review of a hospital discharge summary titled "Death Summary" dated 06/21/13 indicated</p>	F 309			

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F 309	<p>Continued From page 10</p> <p>Resident #1 was taken to the intensive care unit and given fresh frozen plasma and intravenous Vitamin K for severe coagulopathy (no blood clotting). The notes further indicated Resident #1 was grossly bleeding from his upper pharynx (throat) and possible gastrointestinal tract and fresh frozen plasma was of important nature and priority. The notes revealed Resident #1 became less and less responsive and had a respiratory arrest and was pronounced dead at 7:24 PM on 06/21/13.</p> <p>The facility's Director of Nursing and Assistant Administrator were notified of Immediate Jeopardy for Resident #1 on 07/19/13 at 4:26 PM. The facility provided a credible allegation of compliance on 07/20/13 at 4:53 PM. The following interventions were put into place by the facility to remove the Immediate Jeopardy:</p> <p>Resident # 1 was admitted to facility on 10/18/12 as a dialysis patient with chronic kidney failure. On 06/19/13 Resident #1 vomited dark colored liquid . No orders were received to address nosebleed, PT/INR, or acute episode. Facility physician was not notified on 06/20/13 of nosebleed and coumadin dose of 5 milligrams was not held by staff. On 06/21/13 the resident was admitted to the hospital Intensive Care Unit and expired on this date.</p> <p>On 07/19/13 the facility's Quality Assurance Nurse completed a coumadin audit of all residents with orders for coumadin to determine proper dosage administration of coumadin and proper lab result dates. There was no indication of any acute episodes to address. No abnormalities or deficits with PT/INR lab results or coumadin doses were discovered.</p>	F 309		

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NAME OF PROVIDER OR SUPPLIER  CAMELOT MANOR NURSING CARE FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET ST GRANITE FALLS, NC 28630		
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F 309	Continued From page 11  Beginning on 07/20/13 skin assessments for signs and symptoms of bleeding will be completed daily on all residents on coumadin therapy. The facility's QI nurse will monitor daily skin assessments on a weekly basis and report weekly to morning nursing team meeting on Thursdays. If the QI nurse discovers any abnormalities she would report to the charge nurse or Director of Nursing immediately for follow up and notification of physician for interventions.  On 07/19/13 all residents with coumadin orders were re-entered into the electronic medication administration record (e-mar) system to specify new parameters for coumadin administration by the licensed nurse. Parameters set for: nurses only to administer coumadin doses; coumadin doses to be held if INR value greater than 3.0. MD is to be notified for values greater than 3.0 unless otherwise specified per MD.  On 07/19/13 all nursing staff was inserviced by the Administrative Nursing Staff on the administration of coumadin. Content of this inservice included: new Coumadin log, PT/INR results and how coumadin affects coagulation time and nurses only to give coumadin. The eMAR alerts the medication aide that the nurse has to administer the coumadin. Medication Aides were trained on the new procedure of only nurses administering coumadin. New parameters set on e-mar software for coumadin administration. Signs and Symptoms of bleeding, abnormal INR results and when to notify physician. New tool developed: Hall nurse Daily coumadin Log reviewed. Nurses have been given the signs and symptoms of bleeding related	F 309			

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F 309	<p>Continued From page 12</p> <p>to coumadin dosing and have had the expectation set by the Director of Nursing that they will communicate any of the abnormal signs and symptoms to the Physician immediately. Expectations set with nurses to document full assessment by an RN and interventions initiated based on MD order. Charge Nurse to monitor PT/INRs on a daily basis and implement adjustment to coumadin as ordered. Hall nurses to document daily in nursing notes the daily dose of coumadin, the last PT/INR result and the next date for the PT/INR and the diagnosis for the coumadin. Hall nurses will keep the coumadin log up to date and maintain documentation on a daily basis and will refer to the log before coumadin administration. Charge Nurses are to assess the resident with any report of acute symptoms and notify practitioner on call to obtain orders for intervention (s). Staff will not be permitted to work until they have received this inservice training.</p> <p>Starting on 07/22/13 the DON will review all new coumadin orders in daily morning nursing team meetings to ensure accuracy. Charge Nurse will review coumadin log in daily morning nursing team meetings to ensure new orders for coumadin changes are implemented and new orders for labs are being processed.</p> <p>QI Nurse will complete weekly audits of coumadin log which includes labs and dates, diagnosis for coumadin dose and changes. QI nurse will report weekly audits to morning nursing team meetings on Thursdays of each week. QI nurse will audit staff response time to abnormal labs and/or signs and symptoms of abnormal bleeding and report weekly.</p>	F 309			

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F 309 Continued From page 13  
Results of the QI Nurse coumadin Audit weekly which includes the staff's response to ensure well-being of each resident will be presented to the facility's Quality Improvement Committee by July 25, 2013.

F 309

Immediate jeopardy was removed on 07/20/13 at 5:15 PM when interviews with nursing staff revealed awareness of expectations to assess residents who received coumadin therapy for bruising or bleeding or changes in condition and to obtain medical interventions for the resident. The nursing staff confirmed they had received inservice training on 07/20/13. Record reviews of residents in the facility that were on coumadin revealed nurses notes and assessment documents regarding their current condition. There were no residents identified who had vomiting, bruising or bleeding.

F 323  
SS=J 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

F 323

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 review, resident interview and staff interviews the facility failed to prevent 1 of 7 sampled cognitively impaired residents, who were assessed as being at risk for elopement, from exiting the facility and leaving

To address the requirement of F323 at J to (D) Free of Accident Hazards/Supervision/and assistance devices and-to ensures 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. The following action plan was implemented:

1. To correct the cited deficiency, for resident #13 who eloped from the facility without staff's knowledge the following action was taken:

- Resident #13 was placed on three to one supervision.
- Resident #13 was reassessed for Elopement risk

7/16/2013

7/19/2013

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F 323	<p>Continued From page 14</p> <p>the facility's grounds. Resident #13 eloped from the facility and left the facility's grounds on 07/14/13 and 07/15/13 while unsupervised. On 07/14/13 Resident #13 was found by staff at a private residence 0.3 miles away from the facility and on 07/15/13 Resident #13 was found by staff walking next to a roadway approximately 0.2 miles away from the facility. (Resident #13)</p> <p>Immediate Jeopardy began on 07/14/13 when Resident #13 eloped from the facility without staff's knowledge that he was outside without supervision. Immediate jeopardy was removed on 07/20/13 when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put in place and completion of employee training.</p> <p>The findings included:</p> <p>Review of the facility's "Wandering and Elopement Residents" Policy and Procedure, which was revised on July 2011, specified the following:</p> <p>"A. Residents are assessed on admission for possible elopement potential. If considered a concern, the secure guard bracelet will be placed on the resident."</p> <p>"2. All residents wearing the secure guard bracelets will be routinely monitored as to location in the facility. Staff assigned to routinely monitor the resident will enter the activity in the Electronic Medical Record."</p>	F 323	<ol style="list-style-type: none"> <li>2. Social Worker began search for a facility where the resident would be allowed to smoke.               <ul style="list-style-type: none"> <li>➤ Resident was discharged to another facility that allows residents to smoke</li> </ul> </li> <li>3. Nurse #1 was terminated due to failure to follow elopement policy</li> <li>4. All facility staff were educated and continue to be educated in new employee orientation, staff meetings, and on nursing hall team huddles meeting on facility's elopement procedures.</li> <li>5. Wander-guard devices and bracelets are made available to all staff members by being stored in the medication room.</li> <li>6. Nursing staff members have been assigned and trained on the use of the wander-guard tester to check resident's with wander-guards for proper operation of the device (Secure Care device) and bracelets every two hours.</li> <li>7. All residents that have been assessed as potential for wandering that do not need bracelets are also checked q 30 minutes for their location in the facility by an assigned nursing staff member               <ul style="list-style-type: none"> <li>➤ Staff are assigned on daily staffing sheets</li> </ul> </li> <li>8. All residents were reassessed for elopement risk by administrative staff and care plans were updated to reflect assessment</li> </ol>	<p>7/19/2013</p> <p>7/19/2013</p> <p>7/22/2013</p> <p>8/31/2013</p> <p>8/31/2013</p> <p>7/19/2013</p> <p>7/19/2013.</p> <p>7/18/2013</p>
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F 323	<p>Continued From page 15</p> <p>Resident #13 was admitted to the facility on 07/09/13. The resident's "Nursing Admission Assessment" completed on 07/09/13 specified problems with short term memory and severely impaired cognitive skills for daily decision making. Review of Resident #13's 07/09/13 "Elopement Risk Assessment" revealed he was an elopement risk due to being a new admission to the facility, having impaired cognition with poor decision making skills, being able to ambulate independently and having visual or auditory deficits.</p> <p>Review of Resident #13's nursing notes from 07/09/13 to 07/18/13 revealed the following entries:</p> <p>07/09/13 at 7:07 PM: "Resident is alert but has confusion keeps stating that he can walk up the road and smoke and go to _____ (a fast food restaurant) ... Found 2 packs of cigs and lighter in pocket resident stated he did not have any but gave me permission to search, states he cannot stay here without cig."</p> <p>07/14/13 at 4:38 AM: "He still makes attempts to leave whenever he can and goes outside to smoke up the hill."</p> <p>07/15/13 4:48 AM: "Resident has has (sic) been in facility 5 days and is begining (sic) to adjust to surroundings. He still makes attempts to leave whenever he can and goes outside to smoke up the hill."</p> <p>07/15/13 at 6:27 PM: "Resident noted to have left building was walking on side Sunset Blv CN (Charge Nurse) escorted resident back to facility</p>	F 323	<p>9. The ADON updated the facility's wander-guard list to include all resident's with wander-guards. 7/18/2013</p> <p>10. Wander-guard list is continually updated as new residents are admitted and assessed. 8/31/2013</p> <p>11. Facility Maintenance and Nursing staff checked all resident's with wander-guards for placement and operation. Audit revealed all wander-guards to be functioning properly. 7/19/2013</p> <p>12. Checks are completed by nursing staff every two hours and recorded on the Wanderings and Elopement Risk Resident audit sheet</p> <p>➤ Staff member to report any variations to Charge Nurse 7/19/2013</p> <p>13. Electronic care guides were updated by IT staff to trigger checks and documentation by nursing assistants every q30 minutes on each resident assessed for the need for Wander-guards ensuring that each resident is present in the facility and wearing a Wander-Guard. 7/19/2013</p> <p>14. Director of Nursing reviews the Wandering and Elopement Risk forms for documentation every morning in the morning interdisciplinary team meeting 8/31/2013</p> <p>15. Daily completion and checks for documentation will continue for 4 weeks on a continual basis, checks will then be reduced to 7a-3p every day x 4 weeks 8/31/2013</p>	<p>7/18/2013</p> <p>8/31/2013</p> <p>7/19/2013</p> <p>7/19/2013</p> <p>7/19/2013</p> <p>8/31/2013</p> <p>8/31/2013</p>
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F 323	<p>Continued From page 16</p> <p>wanderguard appllied (sic) to ankle explained to resident this is an alarm to make the staff aware if resident attempted to exit the building without assist, resident tolerated well."</p> <p>07/16/13 at 4:19 PM: "Resident ambulates, alert. He is one on one care now, wears wanderguard to protect from wandering off again."</p> <p>07/18/13 at 6:11 PM: "Confiscated a lighter from resident while he was taking a shower. Resident placed lighter on shower ledge, sitter informed this nurse that resident had lighter. Re-educated resident that he was not allowed to have a lighter or cigarettes. Resident states that he understands. Will continue to monitor."</p> <p>Review of Resident #13's "Elopement Risk Assessment" completed 07/18/13 specified; "Resident has had two elopements since admission to facility. One on 07/14/2013 and one 07/15/2013. Both times resident left facility and walked to a house nearby, where he knows the people that live there. he (sic) gets a cigarette from them and smokes. Resident has been picked up both times. Resident has had several wanderguards placed and resident removes them. Resident has been placed on 1:1 care at all times due to high risk for elopement."</p> <p>Review of Resident #13's medical record revealed staff did not document any checks of the resident's Wander-guard from 07/13/13 at 10:00 PM to 07/15/13 at 11:00 PM.</p> <p>Interview with Nurse #1 on 07/18/13 at 2:30 PM revealed that Resident #13 did exit the facility and leave the facility's grounds while unsupervised on 07/14/13 and 07/15/13. Nurse #1 specified that</p>	F 323	<p>16. Check to be completed on a daily shift basis and documented by the nursing assistants on the electronic medical record q30 mins and q2 hrs. for appropriate functioning of the wander-guard. Charge Nurse to oversee the process</p> <ul style="list-style-type: none"> <li>➤ Nurse will audit weekly x 4 weeks for compliance, then monthly thereafter and report quarterly to the QA/PI Committee. until compliance is maintained.</li> </ul> <p>17. Director of Nursing reported results of elopement prevention checks to the QAPI Committee</p> <ul style="list-style-type: none"> <li>➤ Quarterly reports will be reported to the QA/PI Committee until compliance is maintained.</li> </ul> <p>18. Inservices on the facility's existing wandering resident and elopement policy were presented to all staff by the facility's Staff Development/Quality Improvement Nurse. Staff were educated to immediately report any resident that cannot be located to the Charge Nurse.</p> <p>19. Screening prior to admission by the Interdisciplinary Team. Director of Nursing to ensure the potential resident is appropriately placed and can be cared for by facility staff is on ongoing. Evidenced by initials and/or signatures on coversheet of FL-2, signifying review.</p>	<p>8/31/2013</p> <p>8/31/2013</p> <p>7/25/2013</p> <p>7/20/2013</p> <p>8/31/2013</p>
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F 323	<p>Continued From page 17</p> <p>on 07/14/13 the facility was notified by an outside phone call that Resident #13 was observed off the facility's grounds. Nurse #1 stated that she immediately drove to find Resident #13 and located him at a private residence. Nurse #1 stated when she located Resident #13 he was smoking on the porch of the private residence and did not have any visible signs of injury. Nurse #1 stated that she transported Resident #13 back to the facility on 07/14/13 at around 6:30 PM to 6:45 PM and observed that he did not have a Wander-guard in place. Nurse #1 stated that another Wander-guard should have been placed on Resident #13 following his 07/14/13 elopement, but staff could not locate a Wander-guard bracelet to place on Resident #13 when she returned him to the facility. Nurse #1 stated that she did not notify the facility's Director of Nurses (DON) or Administration of Resident #13's 07/14/13 elopement. Nurse #1 explained the only intervention that was implemented by staff on 07/14/13 to prevent Resident #13 from eloping again was to instruct the on duty nursing staff to monitor the resident closely. Nurse #1 stated that on 07/15/13 the facility was again notified that Resident #13 had eloped off of the facility's grounds. Nurse #1 stated that on 07/15/13 she and a transport aide went to locate the resident and they found him walking next to the side of the road smoking a cigarette. Nurse #1 stated that the resident had no visible signs of injury and was transported back to the facility in the facility's van at around 4:15 PM. Nurse #1 stated that when Resident #13 returned to the facility on 07/15/13 he did not have a Wander-guard in place. Nurse #1 stated that upon Resident #13's return to the facility on 07/15/13 staff placed a Wander-guard bracelet on the resident. Nurse #1 stated that the facility's</p>	F 323	<p>20. Facility doors were checked by maintenance staff and found to be functioning properly.</p> <p>21. All doors checked two times a shift by a designated staff member which is noted on the daily schedule. ➤ These checks are being documented on the Door Alarm Functioning Monitoring sheet</p> <p>22. The facility's Wander-Guard and Elopement system including any variances will be reviewed by the QA/PI Committee on a quarterly basis until full compliance is maintained</p>	<p>7/19/2013</p> <p>8/31/2013</p> <p>8/31/2013</p>
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Continued From page 18  
DON was not notified of Resident #13's elopements on 07/14/13 and 07/15/13 until the morning of 07/16/13.

Interview with the facility's DON on 07/18/13 at 2:40 PM revealed that Resident #13 was assessed on his admission date of 07/09/13 to be a high risk for elopements. On 07/09/13 a Wander-guard bracelet was placed on Resident #13 as a preventative measure to keep him from exiting the facility and eloping off the facility's property. The DON stated that staff were directed to check that the resident every thirty minutes to ensure that he was in the facility and that his Wander-guard was in place. The DON specified that staff was also directed to document these resident checks. The DON confirmed that on 07/14/13 and 07/15/13 Resident #13 did not have a Wander-guard in place when he successfully eloped off of the facility's grounds without staff's knowledge. The DON also stated that on 07/14/13 and 07/15/13 staff failed to check Resident #13's Wander-guard to ensure that it was in place and that staff did not notify her of these two elopements until the morning of 07/16/13. The DON specified that staff should have notified her immediately of both elopements to ensure that preventative measures were implemented to prevent further elopements by Resident #13. The DON further stated that if staff had informed her of Resident #13's elopement on 07/14/13 she would have come to the facility and located a Wander-guard to place on the resident and directed nursing staff to implement direct one on one supervision of Resident #13 to prevent another elopement. The DON stated that Wander-guard bracelets were available in the facility on 07/14/13, but staff working on this date did not know where to locate them within the

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F 323	<p>Continued From page 19 facility.</p> <p>On 07/18/13 at 6:15 PM Resident #13 was interviewed. Resident #13 stated he had left the facility's grounds on two occasions to walk down the road to get cigarettes from a man he knew. The resident specified that when he left the facility on the first occasion (on 07/14/13) he was almost run over by a car as he walked along the road which had no sidewalks.</p> <p>On 07/19/13 at 3:38 PM Nurse #1, who located Resident #13 off of the facility's grounds on 07/14/13 and 07/15/13, showed a surveyor where the resident found on both occasions. The location where Nurse #1 found Resident #13 on 07/14/13 was at a private residence approximately 0.3 miles away from the facility's front door. The location where Nurse #1 found Resident #13 on 07/15/13 was along the side of a two lane roadway which had no sidewalks, with a posted speed limit of thirty five (35) miles per hour, which was 0.2 miles away from the facility's front entrance.</p> <p>On 07/19/13 at 9:58 AM an interview was conducted with NA #3. NA #3 stated that she worked on the facility's D-Hall, where Resident #13 resided, on 07/14/13 from 6:00 AM to 7:00 PM. NA #3 reported that on 07/14/13 she was not informed that Resident #13 had eloped from the facility during the afternoon of 07/14/13. NA #3 did not recall if Resident #13 was wearing a Wander-guard on 07/14/13. NA #3 also specified that during her shift on 07/14/13 she was not informed to check on Resident #13 more frequently or to provide him with additional supervision to prevent him from eloping again.</p>	F 323		

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NAME OF PROVIDER OR SUPPLIER  CAMELOT MANOR NURSING CARE FAC	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET ST GRANITE FALLS, NC 28630
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F 323	<p>Continued From page 20</p> <p>On 07/19/13 at 3:17 PM an interview was conducted with Nursing Assistant (NA) #1. NA #1 stated that she worked on the facility's D Hall, where Resident #13 resided, on 07/14/13 and 07/15/13 during the 7:00 PM to 7:00 AM shift. NA #1 stated that on 07/14/13 she found cigarettes in resident Resident #13's room and took the cigarettes to the nurse. NA #1 explained that on 07/14/13 Resident #13 was on the go constantly, usually on the front porch or the facility's gazebo and she did not recall Resident #13 wearing a Wanderguard bracelet on this date. NA #1 reported that Resident #13 eloped from the facility on 07/14/13 and when he returned to the facility, she did not recall being informed to check on him more often or to provide any additional supervision to prevent further elopements. NA #1 reported that she did not recall Resident #13 having a Wander-guard in place until after he eloped from the facility for the second time on 07/15/13. NA #1 stated that nursing assistants are directed to check residents, wearing Wander-guards, every thirty minutes to make sure they are present and have their Wander-guard alarm bracelet in place, but she did not recall Resident #13 wearing a Wander-guard on either 07/14/13 or 07/15/13.</p> <p>On 07/19/13 at 2:49 PM an interview was conducted with NA #2. NA #2 stated that she worked on the facility's D-Hall, where Resident #13 resided, on 07/15/13 from 6:00 AM to 7:00 PM. NA #2 Stated that during the afternoon of 07/15/13 Resident #13 left the facility with a transport aide for a appointment. NA #2 reported that at around 5:00 PM she went to give Resident #13 his medications, but she did not think he had returned from his appointment because he was not in his room, but a nurse informed her that</p>	F 323		

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Resident #13 had returned from his appointment. NA #2 stated that when she went to find Resident #13 she was informed by a resident, who was seated on the facility's front porch, that he had seen Resident #13 walking toward the roadway. NA #2 stated that she reported to Nurse #1 that Resident #13 was missing. NA #2 explained that Nurse #1 went to find Resident #13 in the facility's van and returned with the resident in approximately ten minutes. NA #2 stated that Resident #13 did not have a Wander-guard in place when he returned to the facility, but staff placed another Wander-guard on the resident's ankle upon his return to the facility on 07/15/13.

F 323

Observations on 07/18/13 at 5:02 PM of the facility's A-Hallway exit door, which has a Wander-guard alarm, revealed the door's alarm did not activate when tested by the facility's maintenance staff. Staff had to adjust the door's Wander-guard alarm sensitively in order for the alarm to function properly. Interview with the facility's maintenance staff on 07/18/12 at 5:05 PM revealed the facility's Wander-guard door alarms were checked daily to ensure proper function, but these checks were not documented by staff.

The facility's Director of Nurses and Assistant Administrator were notified of the Immediate Jeopardy for Resident #13 on 7/18/13 at 4:25 PM. The facility provided a credible allegation of compliance on 07/19/13 at 4:00 PM. The following interventions were put into place by the facility to remove the Immediate Jeopardy:

Resident #13 was admitted to the facility on 07/09/13 and was assessed as having severely impaired skills for daily decision making and

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being an elopement risk. On 07/09/13 the facility placed a Wander-guard on Resident #13, as a safety measure, to keep him from exiting the facility without the staff's knowledge. On 07/14/13 Resident #13 left the facility and the facility's grounds, without staff's knowledge, and was located approximately 0.30 miles away from the facility. Resident #13 was brought back to the facility by the charge nurse and the staff determined that the resident had removed his Wander-guard which allowed him to exit the facility without staff's knowledge. On 07/15/13 Resident #13 again exited the facility and left the facility's grounds without staff's knowledge. Resident #13 was located approximately 0.20 miles away from the facility and was brought back to the facility by the charge nurse. Staff did not notify the Director of Nurses until 07/16/13 that Resident #13 had exited the facility and left the facility's grounds on 07/14/13 and 07/15/13. On 07/16/13 Resident #13 was placed on three to one resident to staff supervision and a Wander-guard was again placed on the resident to keep him from exiting the facility without staff's knowledge. The facility's investigation determined that Resident #13 removed his Wander-guard on 07/16/13 and was then placed on one to one direct staff supervision. On 07/18/13 the facility's Assistant Director of Nurses (ADON) completed an "Elopement Risk Assessment" for Resident #13 which identified him as being at high risk for elopement. Staff will keep Resident #13 on one to one direct staff supervision until he is discharged from the facility on 07/19/13 to an assisted living facility.

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On 07/18/13 facility maintenance and nursing staff checked all residents with Wander-guards for placement and operation. All resident

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Wander-guards were found to be functioning properly.

On 07/18/13 all facility doors with a Wander-guard alarm were checked by maintenance staff. The Wander-guard on the facility's A-Hallway exit door was found not functioning. Facility maintenance staff adjusted the alarm to enable the alarm to function properly.

On 07/18/13 all residents were reassessed for elopement risk by administrative nursing staff and changes were made accordingly to wander-guards. Resident care plans were reviewed and updated based on this assessment by the facility's care plan staff.

On 07/18/13 the facility's ADON also updated the facility's Wander-guard list to include all residents with Wander-guards.

On 07/18/13 all care plans, for residents identified as elopement risks were checked and updated as needed by the facility's staff to include a potential for elopement and the resident's need for a Wander-guard. On 07/18/13 Electronic care guides were updated by IT staff to trigger checks and documentation by Nursing Assistants every thirty minutes on each resident assessed for the need for Wander-guards ensuring that each resident is present in the facility and wearing a Wander-guard.

On 07/18/13 a designated staff member as assigned by Human Resources will be responsible for checking every resident that was identified as high risk for elopement every thirty minutes to ensure that they are present in the facility. This designated staff member will also

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check and document resident Wander-guards every two hours for placement and proper function. This will be documented on the "Wandering and Elopement Risk Residents-Monitoring Check List." Any identified problems will be reported to the Charge Nurse. The charge nurses will be responsible for overseeing this process and will report any variances immediately to the Director of Nurses who will be responsible for appropriate intervention. This intervention will be continued for four weeks to determine if there have been no further resident elopements.

On 07/18/13 In-services on the facility's existing wandering resident and elopement policy were presented to all staff by the facility's Staff Development/Quality Improvement nurse. Staff will be educated to immediately report any resident that can not be located to the charge nurse. The charge nurse is responsible for calling a code Orange to alert staff of a missing resident. The charge nurse is to report this to the Director of Nurses. Upon return of the missing resident staff will place the resident on one to one direct staff supervision until further assessment by the Interdisciplinary team, including the DON, and interventions will be implemented as needed to keep the resident safe. Staff will not be permitted to return to work until they have received this inservice training.

On 07/19/13 Residents will be screened prior to admission by the Interdisciplinary team/Director of Nurses to ensure the resident is appropriately placed and can be cared for by facility staff.

On 07/19/13 all facility doors with a Wander-guard alarm were checked by

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F 323	Continued From page 25 maintenance staff and all door alarms were found to be functioning properly. All doors with Wander-guard alarms will be tested two times a shift for fourteen days by a designated staff member as assigned by Human Resources. These checks will be documented on the "Wandering Residents - Monitoring Check List".  Review of the facility's Wander-guard and Elopement system, including any variances, will be reviewed by the facility's Quality Improvement Committee every three months.  Immediate Jeopardy was removed on 07/20/13 at 5:15 PM. Observation revealed all residents, who were identified as elopement risks, were inside the facility, all resident Wander-guards and Wander-guard door alarms were functioning properly. All resident elopement risk assessments were verified as being complete. Interviews conducted with staff in all departments and who worked on all shifts confirmed that they had received inservice training on the facility's elopement policy and procedures.	F 323		
F 329 SS=J	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a	F 329	To address the cited deficiency for F329 483.25 (I) Drug Regimen is free from unnecessary drugs and that the facility failed to call the physician for orders for a laboratory test to check the clotting time of a resident's blood and failed to hold the daily dosage of Coumadin (blood thinner) in a resident with a nosebleed in 1 of 10 residents on Coumadin Therapy (Resident #1. The following action plan was implemented:  1. Nurse #2 was terminated due to failure to call MD and administration of Coumadin in the presence of active bleeding.	7/23/2013

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F 329	Continued From page 26 resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to call the physician for orders for a laboratory test to check the clotting time of a resident's blood and failed to hold the daily dosage of coumadin (blood thinner) in a resident with a nosebleed in 1 of 10 residents on coumadin therapy. (Resident #1).  Immediate Jeopardy began on 06/19/13 when Resident #1 vomited dark colored liquid. Immediate jeopardy was removed on 07/20/13 at 5:15 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 ensure monitoring of systems put into place are effective and completion of employee training.  The findings included:	F 329	2. Nurse #3 received written counsel regarding failure to assess and notify MD when communication received from Nurse #2 3. Nurse #1 was terminated 4. All Nursing Staff educated on the symptom of bleeding and on the importance of notifying the M.D. to received orders for further intervention i.e. Packing nostrils, holding Coumadin, need for laboratory results, etc., 5. Facility notified Medical Director of recent circumstances and updated on outcomes by Director of Nursing. 6. Inservice given to all Nursing Staff that administer medications which included; > Nurses only to administer > Coumadin, Medication Aides will not be allowed to administer Coumadin dosages due to the assessment parameters that have been initiated. 7. All residents on Coumadin will be assessed daily Assessment documented in the wound/skin manager > Program to include; > Any signs and symptoms of Bleeding; > Current dosage of coumadin; > Last INR value > Next scheduled INR > Diagnosis for Coumadin usage > Any changes to Coumadin dosage 8/31/2013 8. Information will be documented daily on the newly implemented "daily Hall Nurse Coumadin Log" > This change has been made to assure that each Resident has been assessed for signs and symptoms of bleeding. 9. The E-MAR program was utilized to allow for the addition of parameters being set to include the acceptable INR range and documentation of the 5 p.m. Coumadin dose. The E-MAR will then direct the nurse to call the M.D. if the value is greater than 3.0 unless otherwise ordered. > The program will not allow the nurse to give the Coumadin until the doctor has been notified and order received. 7/19/2013 10. The E-Mar program was utilized to allow For the addition of parameters being set to Include the acceptable INR range and Documentation of the 5.00 P.M. Coumadin	7/23/2013 7/23/2013  7/19/2013  7/20/2013  7/19/2013  8/31/2013  7/19/2013	



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F 329	Continued From page 28 Resident #1 received coumadin 5 mg. by mouth daily at 5:00 PM.  A review of the most recent laboratory results for a PT/INR with a collect date of 05/29/13, received date of 05/30/13 and a reported date of 05/31/13 indicated (PT) 23.9 (High) with a reference range of 11.5 to 14.1 seconds and (INR) 2.33 (High) with a reference range of 0.89 -1.16.  A review of a MAR dated 06/01/13 through 06/20/13 indicated Resident #1 received coumadin daily by mouth at 5:00 PM.  A review of a nurse's note dated 06/19/13 at 10:12 AM indicated Resident #1 vomited small amount of dark liquid this morning.  A review of the MAR indicated Resident #1 was given coumadin on 06/19/13 at 5:00 PM by medication aide #1.  A review of nurse's notes dated 06/20/13 at 6:03 AM indicated medications were held due to "nausea."  A review of nurse's notes dated 06/20/13 at 11:38 AM indicated Resident #1 was at dialysis.  A review of a treatment sheet from the dialysis center dated 06/20/13 in a section titled Pre -Dialysis "other comments" indicated Resident #1 's nurse from the facility called and stated Resident #1 was vomiting today and yesterday and vomit was dark but not coffee ground consistency. Upon arrival at dialysis Resident #1 stated he had been vomiting for 3 days. A section titled "Treatment Data" indicated Resident #1 had dialysis started on 06/20/13 at 10:25 AM	F 329	for improved communication with nurses to physicians, Nurse Practitioners and Physician Assistants.  15. Communication and Progress Note for New Symptoms, Signs and Other changes in Condition SBAR (Situation, Background, Assessment, and Request) communication to be used prior to exchange of information with advanced practitioners.  16. The Administrative Nursing Team will in-service all nurses on a procedure that allows members of the healthcare team to communicate patient information in a concise manner.  17. The goal of this review and implementation of SBAR is to provide a vehicle for team members to communicate the following: o Situation, Background, Assessment and Recommendations  18. The characteristics of effective communication will include: > Complete: communicate all relevant Information while avoiding unnecessary detail Clear: Use information that is plainly understood (layman's terminology with patients and their families; standard terminology with Healthcare professions); Brief: be concise; Timely; avoid delays in relaying Information that could compromise a patient's situation.  19. Director of Nursing will assess effectiveness of program by review of each patients chart when sent to the hospital or when an acute situation occurs.  20. Report will then be given to the QA/PI Committee on a quarterly basis as part of the Nursing QI quarterly report.	8/31/2013  8/31/2013  8/31/2013  8/31/2013  8/31/2013  8/31/2013

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F 329	<p>Continued From page 29</p> <p>and completed it at 1:56 PM. The notes also indicated Resident #1 was alert, denied complaints and had no nausea or vomiting. A section titled Post - Dialysis indicated no new complaints or observations developed during dialysis and Resident #1 was discharged back to the facility.</p> <p>A review of the MAR indicated Resident #1 was given coumadin on 06/20/13 at 5:00 PM by Nurse #2.</p> <p>A review of a nurse's note dated 06/20/13 at 7:39 PM indicated Resident #1 continues on coumadin 5 mg. by mouth. The notes further indicated Resident #1 was noted to have a nosebleed from right nostril.</p> <p>A review of a nurse's note dated 06/21/13 at 12:29 AM indicated Resident #1 continues coumadin 5 mg. as ordered and nose had stopped bleeding at this time.</p> <p>A review of a nurse's note dated 06/21/13 at 10:45 AM indicated dialysis center called and reported Resident #1 had been sent to the hospital for evaluation and treatment.</p> <p>A review of a nurse's note dated 06/21/13 at 5:44 PM indicated a call was received from a physician at the hospital that Resident #1 had been admitted to the intensive care unit.</p> <p>A review of a nurse's note dated 06/21/13 at 6:44 PM titled "addendum" indicated a physician from the hospital called the facility and reported that Resident #1's blood was "too thin" and Resident #1 "was not in good shape."</p>	F 329		

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F 329	<p>Continued From page 30</p> <p>A review of a hospital laboratory report dated 06/21/13 titled "coagulation" indicated a statement next to PT "no coagulation" and there were no results or notes for INR.</p> <p>A review of a hospital history and physical dated 06/21/13 indicated Resident #1 was to have dialysis today but was vomiting dark brown material and was sent to the emergency room (ER) for evaluation. The notes indicated Resident #1 was chronically ill appearing, poorly unresponsive with respiratory distress and a PT/INR was drawn and the results revealed his blood was not coagulable (was not clotting). The notes revealed Resident #1 was admitted to the intensive care unit, received 2 units of fresh frozen plasma and intravenous Vitamin K.</p> <p>A review of a hospital discharge summary titled "Death Summary" dated 06/21/13 indicated Resident #1 was taken to the intensive care unit and given fresh frozen plasma and intravenous Vitamin K for severe coagulopathy (no blood clotting). The notes further indicated Resident #1 was grossly bleeding from his upper pharynx (throat) and possible gastrointestinal tract and fresh frozen plasma was of important nature and priority. The notes revealed Resident #1 became less and less responsive and had a respiratory arrest and was pronounced dead at 7:24 PM on 06/21/13.</p> <p>During a phone interview on 07/19/13 at 9:22 AM with a dialysis nurse she explained Resident #1 received dialysis treatments on Monday, Wednesday and Friday of each week. She further explained Resident #1 was seen in the dialysis center on Thursday 06/20/13 and received a treatment because he missed his</p>	F 329			

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NAME OF PROVIDER OR SUPPLIER  CAMELOT MANOR NURSING CARE FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET ST GRANITE FALLS, NC 28630	
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F 329	<p>Continued From page 31</p> <p>dialysis treatment on Wednesday 06/19/13 due to vomiting. She stated the facility had reported to them that Resident #1 had been vomiting for 3 days and it was a dark brown cola color. She further stated a lab test for a hemoglobin was drawn on 06/20/13 and the results were 12.0 (Low) with a reference range 14.0-18.0 gram per deciliter but there was no PT/INR drawn because he was not due for his monthly PT/INR until the end of June 2013 and he did not have symptoms at the dialysis center to cause them to question what his PT/INR results were. She explained he was sent back to the facility mid afternoon on 06/20/13 and confirmed Resident #1 did not have a nosebleed while in the dialysis center. The dialysis nurse stated Resident #1 came to the dialysis center again on Friday 06/21/13 but they did not put him on a dialysis machine because he was lethargic, had labored breathing and was slow to respond to dialysis staff's questions. She explained Resident #1 requested to be sent to the ER and confirmed they did not draw any labs at the dialysis center because they knew labs would be drawn in the ER.</p> <p>During a phone interview on 07/19/13 at 9:56 AM Nurse #2 verified she worked from 7:00 AM to 7:00 PM and was assigned as Resident #1's nurse on 06/20/13 and he did not look right to her when she saw him that morning. She explained Resident #1 was coughing up a dark brown liquid and she was concerned because she knew Resident #1 had a history of stomach bleeding. She stated Resident #1 went to dialysis that morning and she thought they would send him to the hospital but he came back to the facility that afternoon. Nurse #2 explained a Nurse Aide (NA) called her to Resident #1's room and he was sitting in his wheelchair and was bleeding from</p>	F 329		



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F 329	<p>Continued From page 32</p> <p>his nose. Nurse #2 verified Resident #1 received Coumadin 5 mg. by mouth at 5:00 PM because she thought Resident #1 had scratched at his nose and that caused the nosebleed. She confirmed she did not call the facility physician to ask if the coumadin dosage should be held or to request laboratory testing for a PT/INR. Nurse #2 stated when she returned to work on 06/21/13 Resident #1 looked worse and his skin color was paler but he was alert and responded to her. She explained Resident #1 went to the dialysis center again that morning and was sent to the hospital from the dialysis center.</p> <p>During an interview on 07/19/13 at 4:35 PM the Director of Nursing (DON) stated it was her expectation for nurses to call the facility physician to report Resident #1's nosebleed. She further stated they should have questioned whether to give the daily coumadin dosage since Resident #1 was bleeding and should have gotten orders to have a PT/INR drawn.</p> <p>During an interview on 07/19/13 at 4:46 PM the facility physician stated if a resident on coumadin therapy had significant bleeding a PT/INR should be obtained. The facility physician verified he was not notified of Resident #1's nosebleed on 06/20/13.</p> <p>During an interview on 07/19/13 at 5:24 PM with Nurse #3 he verified he worked 7:00 AM to 7:00 PM on 06/20/13 and was assigned as the charge nurse. He explained when Resident #1 returned from the dialysis center Nurse #2 reported he had bleeding from his nose and was vomiting dark brown liquid. He explained Resident #1 had a communication sheet from the dialysis center but it didn't have any notes about bleeding or labs.</p>	F 329			

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F 329	<p>Continued From page 33</p> <p>He stated he should have followed through and called the facility physician or physician's assistant to find out what they needed to do but he didn't recognize the seriousness of what was going on. He stated he did not recall looking at previous PT/INRs lab results but probably didn't. He confirmed Resident #1 received coumadin 5 mg. by mouth at 5:00 PM on 06/20/13 and they should have questioned whether to give the coumadin since Resident #1 was bleeding from his nose. Nurse #3 stated they should have notified the facility physician at the point Resident #1 had the nosebleed, should have requested a PT/INR be drawn, held the coumadin dosage and considered Vitamin K. He further stated he was slow to pick up on the fact that dialysis had not done a PT/INR</p> <p>During an interview on 07/19/13 at 5:51 PM with Nurse #1 she verified she was the charge nurse on Friday 06/21/13. She explained Nurse #2 told her that morning Resident #1 had a nose bleed the day before and he was vomiting a dark brown cola colored liquid. She stated Resident #1 went to the dialysis center between 9:30 AM and 10:00 AM and later that day the dialysis center called her and told her Resident #1 was sent to the hospital.</p> <p>During an interview on 07/19/13 at 5:59 PM the DON verified there was no notification to the facility physician or physician's assistant of Resident #1's nosebleed. She also verified there was no request for a PT/INR to be drawn or for the coumadin to be held on 06/20/13.</p> <p>The facility's Director of Nursing and Assistant Administrator were notified of Immediate Jeopardy for Resident #1 on 07/19/13 at 4:26 PM.</p>	F 329			

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F 329	<p>Continued From page 34</p> <p>The facility provided a credible allegation of compliance on 07/20/13 at 4:53 PM. The following interventions were put into place by the facility to remove the Immediate Jeopardy:</p> <p>Resident # 1 admitted to facility on 10/18/12 as a dialysis patient with chronic kidney failure. On 06/19/13 Resident #1 vomited dark brown liquid. No orders were received to address nosebleed, PT/INR, or acute episode. Facility physician was not notified on 06/20/13 of nosebleed and coumadin dose of 5 milligrams was not held by staff. On 06/21/13 the resident was admitted to the hospital Intensive Care Unit and expired on this date.</p> <p>On 07/19/13 an audit of coumadin logs and ordered labs for all residents on coumadin therapy was completed by facility's QI nurse. No concerns were identified.</p> <p>As of 07/19/13 a change to our medication administration system was implemented. Medication Aides will not longer administer coumadin doses. Only licensed nurses will be allowed to administer coumadin. This change has been made to assure that each resident has been assessed for signs/symptoms of overt bleeding.</p> <p>On 07/19/13 the eMAR program was utilized to allow for the addition of parameters being set to include the acceptable INR range and documentation of the current INR prior to allowing the nurse to administer the 5pm coumadin doses. The eMAR will then direct the nurse to call the MD if the value is greater than 3.0 unless otherwise ordered. The program will not allow the nurse to give the coumadin until the doctor</p>	F 329			

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F 329	<p>Continued From page 35 has been notified and orders received.</p> <p>On 07/19/13 the Staff Development Coordinator/Quality Improvement Nurse began inservicing all nurses prior to giving a coumadin dose and content of this inservice included: a new coumadin log; PT/INR results and how coumadin affects coagulation time and nurses only to give coumadin. The inservice also included documentation on the nurse's daily coumadin logs and nurse's documentation in the nurse's notes to include diagnosis, current coumadin dose, next INR date, acknowledge lack of / presence of signs/symptoms of overt bleeding and on the functioning of the facility's e-MAR system. Nurses will not be permitted to work until they have received this inservice training.</p> <p>On 07/20/13 all medication aides were inseediced by Administrative nursing staff on changes to coumadin administration: Medication Aides were trained on the new procedure of only nurses administering coumadin. Medication aides will not be permitted to work until they have received this inservice training.</p> <p>The process change will be evaluated for compliance on a daily basis in the morning nursing meetings by review of order entry on new orders and review of documentation of nurse's coumadin administration. The facility's QI nurse will audit charts of resident on coumadin weekly and report finding on Thursdays in morning nursing team meeting.</p> <p>The Director of Nursing will report weekly audits related to Coumadin quarterly to the facility's Quality Improvement Committee with plans to correct any deficits.</p>	F 329			

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F 329	Continued From page 36  Immediate jeopardy was removed on 07/20/13 at 5:15 PM. Observations of a coumadin log was in place for each resident who received coumadin and had spaces for the documentation of the current coumadin dosage, the date and results of the last PT/INR and when the next PT/INR was due to be drawn. Interviews with nursing staff revealed they had received in-service training on 07/20/13 regarding the administration of coumadin. They explained a new daily coumadin log had to be filled out every shift, skin assessments were to be done every shift, and a nurses note was to be written with the resident's diagnosis, PT/INR results, next due date for PT/INR, and coumadin dosage. They further stated they were expected to call the facility physician if PT/INR results were abnormal or when a resident had bleeding or bruising. They explained only nurses could give the coumadin and medication aides could no longer give coumadin. They explained the INR results had to be put in the e-MAR before they could give the coumadin and the e-MAR would not allow the nurse to give the coumadin until the physician had been notified and orders received.	F 329			