

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

PRINTED: 06/03/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345113</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/13/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>WILLOW CREEK NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281 SS=G	<p><b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b></p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews and record review, the facility failed to process a new order for pain medication for 5 days after it was prescribed for 1 of 3 (resident #1) residents reviewed for pain. Findings included:</p> <p>Resident #1 was admitted to the facility on 2/5/10 with cumulative diagnoses of coronary artery disease, Alzheimer's Disease, gout, adult failure to thrive and diabetes. The most recent Minimum Data Set (MDS) was a significant change MDS dated 4/1/14 which indicated resident #1 had severe cognitive impairment and required extensive assistance with bed mobility, total assistance with transfers, supervision for eating and total assistance with hygiene, bathing and toileting. He was coded for scheduled pain medication with no presence of pain.</p> <p>According the facility incident report and nursing note dated 4/16/14, resident #1 developed an open area to his right ankle on 4/16/14. He was scheduled to see the physician at the wound clinic on 4/23/14 at which time the wound clinic physician documented the right ankle was "fairly constant 4 out of 10" for pain. The wound clinic orders indicated resident #1 was prescribed Lortab, a narcotic analgesic every 4-6 hours as needed for pain on 4/23/14.</p> <p>A review of the April 2014 medication</p>	F 281	<p>Willow Creek Nursing and Rehab acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>Willow Creek Nursing and Rehab's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Willow Creek Nursing and Rehab reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p> <p>Resident #1's attending physician was notified of the new order for pain medication on 4/28/14 by the hall nurse. The new order for pain medication was processed and transcribed to resident #1's Medication Administration Record (MAR) on 4/28/14 by the hall nurse.</p>	6/10/14	

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

TITLE

(X6) DATE

Electronically Signed

05/27/2014

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	<p>Continued From page 1</p> <p>administration record (MAR) revealed resident #1 had been receiving Tylenol 650mg twice daily since 3/4/14 as ordered for a pressure area to his sacrum but the Lortab for pain ordered 4/23/14 did not appear on the April MAR until 4/28/14 and no doses were documented as given. A review of the May 2014 MAR revealed resident #1 received the Tylenol 650mg twice daily as ordered 3/4/14 and no doses of the Lortab for pain were documented as given.</p> <p>A chart review revealed a hand written physician order dated 4/28/14 for Lortab signed by the facility physician.</p> <p>In an interview on 5/12/14 at 3:30 PM, nurse #1 recalled resident #1 returning from the wound clinic via ambulance and the responsible party (RP) giving her a yellow discharge paper along with an appointment card. She recalled making 2 copies of the yellow paper, one for transport and one for the wound nurse. She put the original in the physician's box for him to write the order for the Lortab. Nurse #1 stated the physician made rounds daily between 2:00 PM-300 PM. Nurse #1 stated resident #1 returned around 5:00 PM from the wound clinic so to her knowledge, the physician did not see the order for the Lortab until the next day. Nurse #1 stated that if resident #1 had voiced pain, she would have contacted the physician and got a one time order for a narcotic in house stock until the physician could come in and write the order using his prescriber number. Nurse #1 stated the facility pharmacy did not accept any narcotic orders from outside providers and that the facility physician had to write the order and put his prescriber number on each narcotic order before the pharmacy would fill the order. Nurse #1 stated resident #1 had never</p>	F 281	<p>Resident # 1 will continue to receive pain medication as prescribed by the physician.</p> <p>A 100% audit was completed of all physician consults from 5/1/14 to 5/13/14 by the Quality Improvement (QI) Nurse to ensure the physicians' recommendations were processed timely to include pain medications. This audit included notification to the physician of the recommendation, orders written, and transcribed to the MAR. All areas of concern were immediately addressed by the QI nurse. All licensed nurses will be re-educated on the facility's process of new orders from consults. The in-service will include the charge nurse signing the resident back in the facility on return from a consultant physician visit, reviewing the physician's consult report for any new orders, notifying the primary care physician (PCP) of the recommended orders, transcribing the orders on the MAR if approved by the PCP and faxing the new order to the pharmacy. Licensed nurses will be educated to call the PCP for any order, such as pain medication, that may be needed prior to the PCP's next visit and review of the Physician's Communication Log. All newly hired licensed nurses will be in-serviced regarding the facility's process of new orders from consults, the charge nurse signing the resident back in the facility on return from a consultant physician visit, reviewing the physician's consult report for any new orders, notifying the primary care physician (PCP) of the</p>		

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F 281	<p>Continued From page 2</p> <p>expressed any pain to her so she did not feel she needed to call the physician for an order that day.</p> <p>In an interview on 5/12/14 at 3:45 PM, the administrator stated he felt the issues were resolved on 4/28/14. He stated he was not aware that there was a narcotic ordered for resident #1 until 4/28/14 when the RP approached him with concerns. He stated he notified the director of nursing (DON).</p> <p>In an interview on 5/12/14 at 3:55 PM, the facility physician stated he did not recall seeing any order for a pain medication for resident #1. He stated he was not aware of resident #1 experiencing pain so he may not have written the order if he saw it on 4/23/14 because he felt it was a "recommendation."</p> <p>In an interview on 5/12/14 at 5:40 PM, nurse #2 recalled on 4/28/14, the RP approached her at her medication cart and inquired when resident #1 last had pain medication because she stated resident #1 complained of "toothache like pain" in his right foot. Nurse #2 stated she reviewed the MAR and only saw the scheduled Tylenol and an order for Tylenol as needed for pain. She informed the RP that resident #1 had not expressed any pain to her but she would follow up with the DON. She stated the DON told her to consult the physician who was currently in the facility to write an order for Lortab. Once the order was written, she faxed it to the pharmacy that same day.</p> <p>In an interview on 5/12/14 at 6:00 PM, the DON stated the expectation was for the nurse to follow up immediately with the facility physician on any orders written by any outside providers and not</p>	F 281	<p>recommended orders, transcribing the orders on the MAR if approved by the PCP and faxing the new order to the pharmacy, and to call the PCP for any order, such as pain medication, that may be needed prior to the PCP's next visit and review of the Physician's Communication Log, during orientation by the Staff Development Coordinator..</p> <p>When a resident returns from an appointment the charge nurse will ensure all new orders are processed timely to include orders for pain medications. The recommendation will be written on the Physician Communication Log and the physician will review, date, and initial when completed. Once the physician has approved the new recommendation, the order will be written on a telephone order sheet, transcribed to the MAR and administered per physician order. Licensed nurses will call the PCP for any order, such as pain medication, that may be needed prior to the PCP's next visit and review of the Physician's Communication Log.</p> <p>A copy of the appointment schedule for all residents, to include resident #1's appointments, will be given to the Director of Nursing or Quality Improvement nurse weekly. The Director of Nursing will review all new consult sheets from resident appointments to ensure new orders have been processed timely to include documentation on Physician Communication Log, physician review and initial, orders written, order transcribed to the MAR, and medication administered</p>		

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F 281	Continued From page 3 just put in his box for him to address on his next facility visit.	F 281	per MD order 5 times per week times 4 weeks weekly x 4 weeks and monthly x 2 months utilizing a QI audit Tool.  All audits and re-education will be reviewed by the QA committee weekly X 4 weeks; monthly X 3 months; to ensure the progress and succession of this plan. Any negative findings will be discussed and this plan altered as needed by the QA committee.		
F 309 SS=G	<b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  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 observation, staff interviews and record review, the facility failed to assess for pain and administer as needed prescribed pain medication prior to a dressing change for 1 of 3 residents (resident #1) reviewed for pain. Findings included:  Resident #1 was admitted to the facility on 2/5/10 with cumulative diagnoses of coronary artery disease, Alzheimer's Disease, gout, adult failure to thrive and diabetes. The most recent Minimum Data Set (MDS) was a significant change MDS dated 4/1/14 which indicated resident #1 had	F 309	Willow Creek Nursing and Rehab acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.  Willow Creek Nursing and Rehab response to this Statement of Deficiencies	6/10/14	

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F 309	<p>Continued From page 4</p> <p>severe cognitive impairment and required extensive assistance with bed mobility, total assistance with transfers, supervision for eating and total assistance with hygiene, bathing and toileting. He was coded for scheduled pain medication with no presence of pain.</p> <p>The last pain assessment was completed on 4/15/14 and indicated resident #1 was not experiencing pain. According to the facility incident report and nursing note, resident #1 developed an open area to his right ankle on 4/16/14. He was scheduled to see the physician at the wound clinic on 4/23/14 at which time the wound clinic physician documented the right ankle unstagable pressure ulcer was "fairly constant 4 out of 10" for pain. The wound clinic orders indicated resident #1 was prescribed Lortab which was a narcotic analgesic every 4-6 hours as needed for pain on 4/23/14. An arterial Doppler ultrasound completed 4/25/14 suggested the area was an arterial ulcer.</p> <p>A review of the April 2014 medication administration record (MAR) revealed resident #1 had been receiving Tylenol 650mg twice daily since 3/4/14 as ordered for a pressure area to his sacrum but the Lortab for pain ordered 4/23/14 did not appear on the April MAR until 4/28/14 and no doses were documented as given. A review of the May 2014 MAR revealed resident #1 received the Tylenol 650mg twice daily as ordered 3/4/14 and no doses of the Lortab for pain were documented as given.</p> <p>In an interview on 5/12/14 at 3:30 PM, nurse #1 recalled seeing the order for Lortab on the discharge paper from the wound clinic and she put the order in the physician box since he had</p>	F 309	<p>does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Willow Creek Nursing and Rehab reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p> <p>Resident #1 was assessed for pain to include the time period during wound care treatments by the charge nurse on 5/13/14. Resident #1 did not have any complaints of pain during the assessment. The physician was notified of resident #1's complaint of pain during treatment on 5/13/14 by the charge nurse. A new order for pain medication was received on 5/13/14 to administer pain medications 30 minutes prior to treatment.</p> <p>One hundred percent of all residents, to include Resident #1, were assessed for pain to include residents that received wound care treatments by the Director of Nursing, Quality Improvement nurse, charge nurses, staff development coordinator, on 5/13/14. One hundred percent of all residents, to include resident #1, progress notes and flow sheets for all resident receiving dressing changes starting 5/01/14 to 5/13/14 were reviewed by Director of Nursing, Quality improvement nurse, charge nurses, and Staff Development Coordinator for documentation of signs and symptoms of pain. All residents identified with having</p>		

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F 309	<p>Continued From page 5</p> <p>already made rounds that day and resident #1 had not expressed any complaints of pain to her. Nurse #1 stated she would have contacted the physician and got a one time order for a narcotic in house stock until the physician could come in and write the order if resident #1 expressed pain.</p> <p>In an interview on 5/12/14 at 3:55 PM, the facility physician stated he did not recall seeing any order for a pain medication for resident #1. He stated he was not aware of resident #1 experiencing pain so he may not have written the order if he saw it on 4/23/14 because he felt it was a "recommendation."</p> <p>In an interview on 5/12/14 at 5:40 PM, nurse #2 recalled on 4/28/14, the RP approached her at her medication cart and inquired when resident #1 last had pain medication because she stated resident #1 complained of "toothache like pain" in his right foot. Nurse #2 stated she reviewed the MAR and only saw the scheduled Tylenol and an order for Tylenol as needed for pain. She informed the RP that resident #1 had not expressed any pain to her but she would follow up with the DON. She stated the DON told her to consult the physician who was currently in the facility to write an order for Lortab. Once the order was written, she faxed it to the pharmacy that same day. There was no documented pain medication administered to resident #1 on 4/28/14.</p> <p>In an interview on 5/13/14 at 10:20 AM, nursing assistant #1 stated resident #1 would tell the staff to be careful washing his right foot because it was so painful. NA #1 stated the nurses were aware his right foot hurt if it was manipulated.</p>	F 309	<p>signs and symptoms of pain Medication Administration Records (MARs) were reviewed to ensure prescribed pain medications were being administered per physician's order by 5/25/14. The physician was immediately notified of all residents having breakthrough pain and ineffective pain management by the Director of Nursing, Quality Improvement nurse, charge nurses, staff development coordinator. An in-service was initiated on 5/13/14, by the Staff Development Coordinator, with all licensed nursing staff regarding pain assessments and pain management to include when residents are having signs and symptoms of pain such as grimacing, verbalization, flinching and other bodily movements that would indicate pain to include during dressing changes. This education will include assessing the resident for pain prior to and during dressing changes, immediately stopping the dressing change if the resident appears to be in pain, providing pain meds as ordered and notifying the physician with new or ineffective pain management by the hall nurse. The in-services will be completed by June 10, 2014. All newly hired licensed nurses will be in-serviced regarding pain assessments and pain management to include when residents are having signs and symptoms of pain such as grimacing, verbalization, flinching and other bodily movements that would indicate pain to include during dressing changes during orientation by the Staff Development Coordinator. This education will include assessing the resident for pain prior to</p>		

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F 309	<p>Continued From page 6</p> <p>In a wound care observation on 5/13/14 at 10:45 AM, the treatment nurse along with the assistance of NA #1 changed the dressing to resident #1's right ankle. When the treatment nurse cleansed the right ankle using normal saline and gauze, resident #1 stated "that hurts." The treatment nurse did not stop rendering care but stated to resident #1 "I ' m almost done." The treatment nurse then applied medihoney gel (an antimicrobial agent) and a foam dressing to the right ankle and secured the dressing with gauze and tape. She stated the treatment was ordered 3 times weekly and this treatment order started 5/7/14. Resident #1 demonstrated outward signs of pain to include labored breathing, grasping the side rail and clenched teeth. The treatment nurse stated she was unsure if resident #1 had anything ordered for pain.</p> <p>In an interview on 5/13/14 at 10:50 AM, the treatment nurse stated resident #1 was known to complain of pain with the dressing changes to his right ankle. She stated she looked at the MAR before the interview and saw he had an order for Lortab. The treatment nurse stated she did not check with the nurse passing medication to see if resident #1 was given anything for pain. The treatment nurse stated she was uncertain if resident #1 had ever received any pain medication prior to the dressing change to his right ankle. The treatment nurse stated if a resident was experiencing pain during a treatment, they should be medicated prior to the treatment to prevent pain. She was unable to explain why she did not ensure resident #1 was medicated prior to his wound care.</p> <p>In a review of resident #1 weekly wound assessment completed by the treatment nurse,</p>	F 309	<p>and during dressing changes, immediately stopping the dressing change if the resident appears to be in pain, providing pain meds as ordered and notifying the physician with new or ineffective pain management by the hall nurse.</p> <p>All residents, to include resident #1, will be assessed for pain on admission by the hall nurse and quarterly by the Minimum Date Set (MDS) nurses utilizing the pain assessment and/or MDS assessment form. The physician will be notified of all residents identified with having new or ineffective pain management by the hall nurse. All residents receiving dressing changes will be assessed for pain by the treatment nurses prior to and during the dressing changes utilizing the pain log. If any resident is identified as having signs and symptoms of pain prior to the dressing change the treatment nurse will administer prescribed pain medication. If no pain medication is prescribed the treatment nurse will notify the physician. If a resident is identified as having pain during a dressing change the treatment nurse will immediately stop the dressing change, assess the resident and administer prescribed pain medication. If no pain medication is prescribed the treatment nurse will notify the physician. Ten residents will be reviewed to ensure pain assessments completed for newly admitted residents, Quarterly MDS assessments completed for pain, and pain logs completed for residents receiving dressing changes by the Quality Improvement (QI) nurse 3x per week x 4</p>		

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F 309	<p>Continued From page 7</p> <p>she documented on 4/17/14 that resident #1 experienced pain to his right ankle with touch. On 4/23/14, the wound assessment completed by the treatment nurse indicated resident #1 experienced pain at times on touch to the right ankle. The wound assessment dated 4/30/14 read "pain on movement and touch" to the right ankle and on 5/7/14, the treatment nurse documented pain described as "tender" on the weekly wound assessment.</p> <p>In an interview on 5/13/14 at 11:10 AM, the director of nursing stated her expectation was that the treatment nurse ensured any resident who expressed pain during a treatment or a dressing change should be pre-medicated 30 minutes before any care.</p>	F 309	<p>weeks, weekly x 4 weeks the monthly x 2 months for completion of the assessment and to ensure that all residents identified with signs and symptoms of pain have been assessed, prescribed pain medications have been administered per physician's order, and the physician has been notified of new or ineffective pain management utilizing a QI tool. The Director of Nursing, Staff Development Coordinator, and the Assistant Director of Nursing will observe dressing changes on 3 residents daily X 14 days then weekly for 4 weeks then monthly X 3 months to ensure If any resident is identified as having signs and symptoms of pain prior to the dressing change the treatment nurse will administer prescribed pain medication, if a resident is identified as having pain during a dressing change the treatment nurse will immediately stop the dressing change, assess the resident and administer prescribed pain medication, and if no pain medication is prescribed or ineffective the treatment nurse will notify the physician utilizing a Dressing Change QI Tool.</p> <p>The Administrator will hold weekly QA meetings X 4 weeks then monthly x 3 months to review the progress of this plan to include reviewing residents' pain observations. This committee has the right to alter this plan as needed based on future observations and concerns.</p>		