

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

JUN 12 2014

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345552	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/14/2014
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NAME OF PROVIDER OR SUPPLIER THE SHANNON GRAY REHABILITATION & RECOVERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2005 SHANNON GRAY COURT JAMESTOWN, NC 27282
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F 166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, observation and record review the facility failed to promptly resolve grievances and inform the resident of the progression toward resolution for 1 of 3 residents (Resident #5) reviewed for grievances.</p> <p>Findings included:</p> <p>Resident #5 was admitted to the facility on 7/11/11. Her diagnoses included history of fall, chronic pain in limb, osteoporosis, peripheral vascular disease, osteoarthritis, and lumbago.</p> <p>Record review of the nursing schedule and MAR for 4/15/14 revealed Nurse #1 was the nurse assigned to Resident #5's hall from 7:00 pm - 7:00 am, and she did not administer any as-needed pain medication to Resident #5 on that date.</p> <p>Record review revealed a grievance for Resident #5 dated 4/16/14. The grievance stated, "Pain medication not administered as [patient] requested. Spoke [with] nursing staff. Staff aware resident requests [as-needed] pain medication frequently and can receive as prescribed. [Patient] made aware of medication regimen." The grievance form indicated the Unit</p>	F 166	<p>Facility representatives met with Resident #5 to make sure any outstanding concern(s) were resolved. The resident voiced satisfaction and understanding with interventions by the facility and with the resolutions to previous concerns. Documentation was generated at that time to reflect this follow up.</p> <p>The facility's Administrator and Social Services Director reviewed all concerns since 4/16/14 to ensure that documentation of concern resolution was thorough and that the resident (and/or their family representative who shared the concern) had been notified of the concern resolution. There are no concerns with outstanding follow-up or resolution issues at this time, 6/9/14.</p>	6/9/14
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Dawn Curtis* TITLE *Administrator* (X6) DATE *6-11-14*

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 wing 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 a 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 166	<p>Continued From page 1</p> <p>Coordinator signed and dated the form on 4/22/14 indicating she followed up with the resident and the resident was satisfied. The form was not signed and dated by either the Administrator or the Social Services Coordinator.</p> <p>Review of the Minimum Data Set (MDS) dated 4/17/14 revealed the resident was cognitively intact, had clear speech, made herself understood and understood others. She did not reject care and received as-needed pain medication.</p> <p>Review of the mental health progress note dated 4/22/14 stated, "[Patient] states she's had more pain in her leg [and] this has led to several misunderstandings [with] staff."</p> <p>Record review of the nursing schedule and MAR for 5/5/14 revealed Nurse #1 was the nurse assigned to Resident #5 's hall from 7:00 pm - 7:00 am, and she did not administer any as-needed Ultram to Resident #5 on that date.</p> <p>Record review revealed a grievance for Resident #5 dated 5/6/14. The grievance stated, "[Resident] reports to me that she asked [Nurse #1] for her [as-needed pain medication] last evening and [Nurse #1] would not administer it to her." The form indicated the Director of Nursing spoke to the resident and the resident was satisfied on 5/7/14.</p> <p>Review of the mental health progress note dated 5/6/14 stated, "[Patient] states she's been in more pain lately [and] the nurse she had trouble [with] last week over pain meds again told her 'They were out of the medicine! No they weren ' t. The day nurse had it!' [Patient] shakes her head</p>	F 166	<p>The facility's Chief Operating Officer in-serviced the administrative employees who are responsible for addressing, resolving and documenting the outcome(s) of resident/family concerns. Future or new administrative team members will be in-serviced as they are hired and their signature(s) will be added to the original in-service which was completed 5/13/14.</p>		

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F 166	<p>Continued From page 2</p> <p>in disgust. [Patient 's] physical condition affecting her mood. [Increased] anxiety. [Patient] responds well to symptom [management and] supportive reassurance."</p> <p>Review of the physician progress note dated 5/9/14 stated, "Continue current plan of care with adjustments to plan as needed to meet goal of symptom control and preservation of current level functioning. Neuropathy is chronic and ongoing. Patient was encouraged to ask for pain medication for breakthrough pain."</p> <p>During an interview on 5/13/14 at 11:48 am Resident #5 stated, "I am exhausted from not having relief from the pain. They are trying a new patch on me. Now I have two. This knee pain is terrible. I had a lot of trouble with (Nurse #1) in the evening because she would not give me the Ultram and would tell me there wasn ' t any. It happened twice. Once last week and once a few weeks ago. I reported it to the day nurse. The nurses are 12 hours now and when she came on in the evening I would have to wait all night for my [as-needed] pain medicine. It seems like someone said there was a form filled out or something when it happened before in April but no one said anything else about it to me. I don ' t know what they did, but it happened again. Last week was the last time I had trouble with that nurse. She said there wasn ' t any Ultram and the nurse the next morning said there was. I just don ' t want her to be my nurse, ever, because of all the problems. It was a terrible feeling, laying here hurting until the morning because there was no one else to get the pain medicine from."</p> <p>During an interview on 5/13/14 at 2:05 pm with Nurse #2, who was a first shift nurse routinely</p>	F 166	<p>The facility modified the process by which concerns are monitored, to better ensure adequate completion. Effective 5/13/14, a corporate employee will review the concern log weekly to make sure new concerns have been handled and documented accordingly. The monitoring will check for completion (an exact time expectation will not be set as some concerns require more in-depth follow up) and evidence of follow up communication documentation by the appropriate facility employee(s). The facility's internal Concern QA form was updated on 5/13/14 to allow for a corporate team member to sign off after it has been reviewed (their signature will indicate the concern has been addressed and communication has been documented). The Concern QA form will not be signed by a corporate staff member until this information has been reviewed and verified.</p>		

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F 166	<p>Continued From page 3</p> <p>assigned to Resident #5, she stated, " [Resident #5 has complained about [Nurse #1] not giving her her [as-needed] pain meds. It started last week or the week before. I know one night [Resident #5] asked me to go ahead and give her a pain pill because she was worried the nurse coming on would not give it to her. That was when it started - a couple of weeks ago."</p> <p>During an interview on 5/13/14 at 4:10 pm, the MDS nurse indicated Resident #5 spoke to her in the hallway, on a date she could not remember " a few weeks ago " and stated [Nurse #1] would not give her her [as-needed] pain medication. The MDS nurse indicated she called the nurse practitioner who indicated Resident #5 could have her [as-needed] pain medication when she requested it. The MDS nurse indicated she called [Nurse #1] to let her know what the nurse practitioner said regarding the resident ' s as-needed pain medication. She further indicated she did not complete a grievance form regarding this issue.</p> <p>During an interview with the Unit Coordinator on 5/13/14 at 4:15 pm, she indicated she was made aware on 4/16/14 that Resident #5 had requested [as-needed] pain medication the previous night but Nurse #1 did not give it. She indicated she did not speak to Nurse #1 about not giving the medication and she did not speak to Resident #5 about her medication concerns. She indicated she put a " general note " in the communication book about [as-needed] medications and spoke to all the nurses " so that one [nurse] would not feel pointed out. " The Unit Coordinator indicated she felt like the concern was handled because she "didn ' t hear anything else about it."</p>	F 166	<p>The facility formed a QA team, the Concern Resolution QA Team, to monitor the efforts of this plan of correction. The initial meeting was on 5/13/14. This team will meet weekly x 4, and then monthly thereafter to ensure compliance with this plan of correction. The Nursing Home Administrator will chair the QA team with oversight provided by the Chief Operating Officer. This information will be reported to the Executive Quarterly QA Committee meeting by the Nursing Home Administrator. The next scheduled meeting for the Executive Quarterly QA Committee will be 7/16/14.</p>		

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F 166	<p>Continued From page 4</p> <p>During an interview with the Administrator on 5/13/14 at 4:30 pm she stated, " I was aware of the [5/5/14] issue with the resident ' s [as-needed pain medication], but not the [4/15/14] issue. The Social Worker logs the grievance when it is resolved and then I sign the completed grievance to indicated completion. She gives to me or puts it in my box to sign. I do not know why the 4/16 was not signed. [The unit coordinator] should have had a conversation with the resident about her not receiving her medication. Whoever is following up with the resident should sign the form stating the resident was spoken to. I expect the pain med issues on the grievance form would have been taken care of that day or the next. I don ' t know why it was dated as resolved 6 days later. " She further indicated the resident should receive her [as-needed] pain medication when requested and it should be available on the cart.</p> <p>During an interview on 5/14/14 at 11:33 am with the DON she indicated Resident #5 did not receive her as-needed pain medication on the 5/5/14 night shift when Nurse #1 could not find it on the medication cart. She indicated the nurses on the floor are responsible for taking medications delivered from the pharmacy out of the pharmacy totes and putting the medications on the cart. The DON stated, " I know [on 5/6/14] [Resident #5] said something about being in pain and not getting her pain medication. "</p> <p>During an interview on 5/14/14 at 12:07 pm Nurse Practitioner #1, she stated, " [Resident #5] has been complaining of increased pain so [the Pain Nurse Practitioner] has been following her as well. I knew there was an issue in April when she didn ' t get her medication. I did speak with [Nurse #1] and told her pain is subjective and</p>	F 166	The facility alleges full compliance with this plan of correction, effective 6/9/14		

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F 166	Continued From page 5 when a resident states they are in pain they should be given [as-needed] pain medication if requested. [Nurse #1] told me she used her nursing judgment but could not give another reason as to why she did not give the medicine. " During a phone interview on 5/14/14 at 6:45 pm with Nurse #1 indicated she recalled an incident in April when the resident did not receive [as-needed] Ultram because the card was empty when she pulled it off the cart. She stated, " I don ' t know anything about 5/5. April was the only time I had issues with the Ultram. She knows exactly what she wants and she can tell you. No one talked to me last week about her Ultram not being given. The only time there was an empty card was in April. " Attempted to clarify dates and occurrences with Nurse #1 but was unable.	F 166			
F 309 SS=D	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 resident and staff interviews, observation and record review the facility failed to administer as-needed pain medication when requested for 1 of 3 residents (Resident #5) reviewed for pain.	F 309	Resident #5 was interviewed on 5/13/14 and voiced satisfaction related to a previous concern about pain management. Resident #5 continues to be followed by a pain specialist. Medication adjustments and monitoring have resulted from these visits, the most recent visit occurred on 6/5/14. New MD orders and changes are documented and resident's care plan has been updated to reflect these interventions and changes.	6/9/14	

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F 309	<p>Continued From page 6</p> <p>Findings included:</p> <p>Resident #5 was admitted to the facility on 7/11/11. Her diagnoses included history of fall, chronic pain in limb, osteoporosis, peripheral vascular disease, osteoarthritis, and lumbago.</p> <p>Record review of the Medication Administration Record (MAR) for April and May 2014 revealed a physician order for the following as-needed pain medications:</p> <ul style="list-style-type: none"> · Norco 10-325 milligrams (mg) by mouth every 4 hours as needed for pain. · Ultram 50 mg by mouth every 6 hours as needed for breakthrough pain. · Lidoderm patch 5% to left sacroiliac joint as needed for pain. On for 12 hours/off for 12 hours. · Lidoderm patch 5% , up to 3 patches, to painful areas on body as needed for pain. On for 12 hours/off for 12 hours. <p>Record review of the MAR revealed a physician order for the following scheduled pain medications:</p> <ul style="list-style-type: none"> · Norco 10-325 mg by mouth at 12 am · 4/15/14 order - Duragesic (Fentanyl) 50 micrograms (mcg) / hour (hr) patch. 1 patch every 72 hours for pain. 5/1/14 order change- Duragesic 50 mcg/hr patch. 1 patch every 48 hours. 5/12/14 order change- Duragesic 50 mcg/hr patch and 12 mcg/hr patches to total 62mcg/hr every 72 hours. <p>Record review of the nursing schedule and MAR for 4/15/14 revealed Nurse #1 was the nurse assigned to Resident #5's hall from 7:00 pm - 7:00 am, and she did not administer any as-needed pain medication to Resident #5 on that</p>	F 309	<p>The facility's Director of Nursing conducted face to face conversations with all interviewable residents to ensure no other resident had an issue with the provision of pain medications. The initial interviews were conducted on 5/14/14 and were documented on a QA interview tool. These interviews have been repeated weekly since 5/14/14 to ensure no other issues were present. Based on the feedback from these interviews, no other interviewable residents have voiced concerns with the provision of pain medications since 5/14/14.</p>		

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F 309	<p>Continued From page 7 date.</p> <p>Record review revealed a grievance for Resident #5 dated 4/16/14. The grievance stated, "Pain medication not administered as [patient] requested."</p> <p>Review of the Minimum Data Set (MDS) dated 4/17/14 revealed the resident was cognitively intact, had clear speech, made herself understood and understood others. She did not reject care and received as-needed pain medication.</p> <p>Review of the mental health progress note dated 4/22/14 stated, "[Patient] states she's had more pain in her leg [and] this has led to several misunderstandings [with] staff."</p> <p>Record review of the nursing schedule and MAR for 5/5/14 revealed Nurse #1 was the nurse assigned to Resident #5's hall from 7:00 pm - 7:00 am, and she did not administer any as-needed Ultram to Resident #5 on that date.</p> <p>Record review revealed a grievance for Resident #5 dated 5/6/14. The grievance stated, "[Resident] reports to me that she asked [Nurse #1] for her [as-needed pain medication] last evening and [Nurse #1] would not administer it to her."</p> <p>Review of the mental health progress note dated 5/6/14 stated, "[Patient] states she's been in more pain lately [and] the nurse she had trouble [with] last week over pain meds again told her. 'They were out of the medicine! No they weren't. The day nurse had it!' [Patient] shakes her head in disgust. [Patient's] physical condition affecting her</p>	F 309	<p>The facility in-serviced all nurses regarding pain medication management and documentation. This in-service was initiated on 5/13/14 and completed on 5/15/14. Future hires (nurses) will receive this in-service during their orientation as well. The pain in-service has been added to the facility's annual education calendar for every March and August (in-service will be repeated every 6 months for nurses) by the Staff Development Coordinator or Director of Nursing.</p> <p>The facility formed a QA team, the Pain Management Team, on 5/14/14. The QA team consists of the Nursing Home Administrator, Director of Nursing and the Unit Coordinators. Additional members can be added as/when needed. The QA</p>	

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F 309	<p>Continued From page 8</p> <p>mood. [Increased] anxiety. [Patient] responds well to symptom [management and] supportive reassurance."</p> <p>Review of the physician progress note dated 5/9/14 indicated Resident #5 could ambulate without assistance, and her osteoarthritis was chronic with ongoing complaints of left lower extremity pain. The physician's plan was to continue her scheduled pain medication and as-needed pain medications. The note stated, "Continue current plan of care with adjustments to plan as needed to meet goal of symptom control and preservation of current level functioning. Neuropathy is chronic and ongoing. Patient was encouraged to ask for pain medication for breakthrough pain."</p> <p>During an observation on 5/13/14 at 11:10 am Resident #5 was walking in the hallway from her room to the dining/sitting area at the nurse's station. She was walking with a slow and steady gait, without any assistive devices.</p> <p>During an interview on 5/13/14 at 11:48 am Resident #5 stated, "I am exhausted from not having relief from the pain. They are trying a new patch on me. Now I have two. This knee pain is terrible. I can ask for my additional pain medicine. Every night at midnight I get Norco for pain. It is just to help the pain through the night. If I have pain I can ask for Norco or Ultram. They are my two additional pain medications. I can have Norco every 4 hours and the Ultram every 6 hours. I had a lot of trouble with (Nurse #1) in the evening because she would not give me the Ultram and would tell me there wasn't any. It happened twice. Once last week and once a few weeks ago. I reported it to the day nurse. The</p>	F 309	<p>team will meet weekly until otherwise indicated and will continue these weekly meetings for no less than 6 months. Their efforts and interventions, including the use of tools such as the Pain Management Tracking Log(s) and Interview QA Tool, will be documented and reviewed during the QA team meeting. These documents will be kept by the Nursing Home Administrator who will serve as the chair of this QA team. Information obtained and generated during these Pain QA meetings will be summarize and then reported to the Executive Quarterly QA Committee meeting by the Director of Nursing. The next Executive Quarterly QA Committee meeting is scheduled for 7/16/14.</p> <p>The facility alleges full compliance with this internal plan of correction, effective 6/9/14.</p>		

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F 309	<p>Continued From page 9</p> <p>nurses are 12 hours now and when she came on in the evening I would have to wait all night for my [as-needed] pain medicine. Last week was the last time I had trouble with that nurse. She said there wasn't any Ultram and the nurse the next morning said there was. I just don ' t want her to be my nurse, ever, because of all the problems. It was a terrible feeling, laying here hurting until the morning because there was no one else to get the pain medicine from."</p> <p>During an interview on 5/13/14 at 2:05 pm with Nurse #2, who was a first shift nurse routinely assigned to Resident #5, she stated, "[Resident #5 has complained about [Nurse #1] not giving her her [as-needed] pain meds. It started last week or the week before. I know one night [Resident #5] asked me to go ahead and give her a pain pill because she was worried the nurse coming on would not give it to her. That was when it started - a couple of weeks ago."</p> <p>During an interview on 5/13/14 at 4:10 pm, the MDS nurse indicated Resident #5 spoke to her in the hallway, on a date she could not remember "a few weeks ago" and stated [Nurse #1] would not give her her [as-needed] pain medication. The MDS nurse indicated she called the nurse practitioner who indicated Resident #5 could have her [as-needed] pain medication when she requested it. The MDS nurse indicated she called [Nurse #1] to let her know what the nurse practitioner said regarding the resident ' s as-needed pain medication.</p> <p>During an interview with the Unit Coordinator on 5/13/14 at 4:15 pm, she indicated she was made aware on 4/16/14 that Resident #5 had requested [as-needed] pain medication the previous night</p>	F 309		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345552	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/14/2014
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F 309	<p>Continued From page 10</p> <p>but Nurse #1 did not give it. She indicated she did not speak to Nurse #1 about not giving the medication and she did not speak to Resident #5 about her medication concerns. She indicated she put a "general note" in the communication book about [as-needed] medications and spoke to all the nurses "so that one [nurse] would not feel pointed out."</p> <p>During an interview with the Administrator on 5/13/14 at 4:30 pm she stated, "I was aware of the [5/5/14] issue with the resident's [as-needed pain medication], but not the [4/15/14] issue. [The unit coordinator] should have had a conversation with the resident about her not receiving her medication." She further indicated the resident should receive her [as-needed] pain medication when requested and it should be available on the cart.</p> <p>During an interview on 5/14/14 at 11:33 am with the DON she indicated Resident #5 did not receive her as-needed pain medication on the 5/5/14 night shift when Nurse #1 could not find it on the medication cart. She indicated the nurses on the floor are responsible for taking medications delivered from the pharmacy out of the pharmacy totes and putting the medications on the cart. The DON stated, "I know [on 5/6/14] [Resident #5] said something about being in pain and not getting her pain medication. Nurse #1 said it was not on the cart. I looked for the Ultram card and found the card but it was somewhere different. The card was not on the cart. I went to every tote in the facility. I found the resident's Ultram in the green tote in the med room on another hallway." The DON called the facility's pharmacy and stated, "The pharmacy said 4/29/14 was the last (Ultram) card sent for</p>	F 309		

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F 309	<p>Continued From page 11</p> <p>[Resident #5] and there were 30 pills." She indicated the resident's Ultram would have been sitting in the tote in the incorrect medication room since it was delivered.</p> <p>During an interview on 5/14/14 at 12:07 pm Nurse Practitioner #1, she stated, "[Resident #5] has been complaining of increased pain so [the Pain Nurse Practitioner] has been following her as well. I knew there was an issue in April when she didn't get her medication. I did speak with [Nurse #1] and told her pain is subjective and when a resident states they are in pain they should be given [as-needed] pain medication if requested. [Nurse #1] told me she used her nursing judgment but could not give another reason as to why she did not give the medicine."</p> <p>During a phone interview on 5/14/14 at 6:45 pm with Nurse #1 indicated she recalled an incident in April when the resident did not receive [as-needed] Ultram because the card was empty when she pulled it off the cart. She stated, "I don't know anything about 5/5. April was the only time I had issues with the Ultram. She knows exactly what she wants and she can tell you. No one talked to me last week about her Ultram not being given. The only time there was an empty card was in April." Attempted to clarify dates and occurrences with Nurse #1 but was unable.</p>	F 309			