

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

AUG 22 2014

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345434	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/17/2014
NAME OF PROVIDER OR SUPPLIER  CARVER LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 321 EAST CARVER STREET DURHAM, NC 27704	
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F 000	INITIAL COMMENTS  The Division of Health Service Regulation (DHSR), Nursing Home Licensure and Certification Section conducted a recertification and complaint investigation health survey on 07/10/14. The survey team went back to the facility on 07/16/14 to 7/17/14 to gather additional information that led to the decision that the facility had substandard quality of care at the immediate jeopardy level. A partial extended survey was conducted on 7/16/14 through 07/17/14 and an exit conference was held with the facility on 07/17/14. The immediate jeopardy began on 6/23/14 and was removed on 7/17/14.	F 000	Credible Allegation of Compliance for 157 The facility provides the following information to show that all the residents at Carver are safe from the discrepancies identified. The facility will continue to build on this QA program to ensure that policies are followed and developed, QA programs initiated and further education and guidance is provided as needed. RESIDENT IDENTIFIED At the time this IJ was announced R263- *Had a C-diff re-culture on 7/9/14 During the survey *MD was aware of the loose stools 7/9/14 during the survey *The Potassium errors have been resolved as 7/14/14 with correct orders. The MD was notified of errors on 7/16/14 and gave no changes in the current treatment plan. *The MD is aware of R 263 condition and is monitoring closely.	7/17/14
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157	IDENTIFYING OTHER RESIDENTS AT RISK 1. A 100% Bowel Movement audit was completed from 7/10- 7/16/14 to identify any residents that are exhibiting persistent diarrhea/loose stools. The facility printed out the CNA bowel movement charting from the Electronic charting. This audit was completed at 9:03pm on 7/16/14. This task was completed by the Nurse Managers. * From this audit R1, R2 and R3 were identified as having a long history of loose stools. The facility notified the MD of these loose stools on 7/16/14 and orders for C-diff cultures were obtained as a safety measure. 2. A 100% lab audit was completed for the last 30 days to ensure all labs were obtained and any orders that were received were transcribed and administered as ordered. The Managers printed	

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

TITLE

(X5) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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 157	<p>Continued From page 1</p> <p>change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff, physician and nurse practitioner interviews, the facility failed to notify or consult with the physician or nurse practitioner that a resident had persistent loose stools which resulted in a 17 day delay in medical treatment for 1 of 2 residents reviewed for Clostridium Difficile (C-Diff) and failed to notify the physician of missed doses of potassium for 1 of 1 resident with a critical potassium level of 2.3 [3.5 - 5.3 reference range] (Resident #263).</p> <p>The immediate jeopardy began on 6/26/14 when Resident #263 had three large loose stools within twenty four hours and neither the physician nor the nurse practitioner was contacted for guidance. The immediate jeopardy was removed on 7/17/14 at 8:47 pm when the facility provided and implemented an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity of D (no actual harm with the potential for more than minimal harm) that is not immediate jeopardy to ensure monitoring systems put in place are effective. Findings included:</p> <p>Lexi-Comp's Geriatric Dosage Handbook, 17th</p>	F 157	<p>out all lab orders from the Electronic Charting system to validate this. This was completed by the nurse managers on 7/16/14 at 9:10 pm.</p> <p>* From this audit no further medication errors in relationship to lab results were observed. The facility did note that 13 labs were not drawn per orders in the last 30 days. The MD was notified of these errors and new orders were obtained.</p> <p>3. A 100% in house resident audit was completed to ascertain if all changes of Condition's were identified by nursing and the MD was aware. This audit was completed from 7/14/14-7/16/14 by the Nurse Managers. This was completed on 7/16/14 @ 10:37 PM.</p> <p>* From this audit there were 19 changes of condition that the facility could not find MD notification. The MD was notified of all changes on 7/16/14 by the nurse managers. Upon notification the MD had no new orders or interventions for these residents.</p> <p>4. A 100% MD order audit was completed from 7/10/14-7/16/14 to ensure that all new orders were entered into the Electronic Charting System as ordered. This process was started on 7/16/14 by the nurse managers. This audit was completed on 7/17/14 @ 3:35pm.</p> <p>* From this audit 4 med errors were noted. The error for R4- the Metformin was ordered and to be held on 7/16/14 and was administered (MD notified and no new received), R5 had multi 2 tabs ordered and 1 tab was transcribed (MD changed to 2 tabs), R6 Facility failed to give Fosamax weekly as ordered for 2 weeks (MD stated to start Fosamax weekly), R7 treatment order of Dry gauze and TAO was ordered 3 times a week and it was transcribed as daily (MD stated to change to 3 times weekly). None of these residents suffered any ill effects related to these errors.</p>

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F 157	<p>Continued From page 2</p> <p>edition in part reads "potassium is the major cation (causes a positive charge) of intracellular (located or occur within the cell) fluid and is essential for conduction of nerve impulses in heart, brain and skeletal muscle; contraction of cardiac, skeletal and smooth muscles; maintenance of normal renal (kidney) function, acid-base balance, carbohydrate metabolism, and gastric (stomach) secretion."</p> <p>Resident #263 was admitted into the facility on 4/28/14. Diagnoses included C-Diff (a type of infectious diarrhea), diarrhea, hypokalemia (low potassium), hypertension, debility (physical weakness), ventriculostomy (an external catheter placed in the ventricles of the brain to drain cerebral spinal fluid) clamped, cerebral aneurysm (area that has become weakened causing the blood vessels in the brain to bulge), dysphagia (difficult swallowing), difficulty walking and general muscle weakness. The admission Minimum Data Set completed on 5/9/14 indicated Resident #263 had short and long term memory problems. Decision making was listed as moderately impaired.</p> <p>A review of the lab report received by the nursing facility on 6/12/14 from the lab provider in part read "clostridium difficile toxin result positive. It was further indicated that the report was "Read back and verified with the director of nursing at 8:55 am."</p> <p>A review of the physician order dated 6/12/14 read "Flagyl 500 mg by mouth three times daily for clostridium difficile for 10 days." The medication administration record (MAR) reflected the last dose of Flagyl was administered on 6/21/14 at 10:00 pm. Flagyl is an antibiotic that is</p>	F 157	<p>PROCESSES IMPLEMENTED TO PREVENT FURTHER OCCURRENCES</p> <p>1. In-servicing for the nursing staff and nursing assistants was started on 7/16/14 by the Nurse Managers. At this point 84 nursing staff and nursing assistants out of 138 have been in-serviced. No member of the nursing staff or nursing assistants will be able to work the floor until they are in serviced.</p> <p>*The facility's Change of Condition Policy and the requirements of MD notification which includes; residents that are experiencing persistent loose stools and have critical potassium levels and other critical/abnormal labs.</p> <p>* The facility's Medication transcription policy which would include the proper transcription of potassium.</p> <p>a. STARTED ON 7/16/14 AND ONGOING AT THIS TIME.</p> <p>2. The Nurse Managers were in-serviced by the Regional Vice President on 7/17/14 on the following:</p> <p>* The Facility's New Morning Nurses QA Meeting which will include:</p> <p>*Review of the 24 hour condition report to ensure that all residents that have exhibited persistent loose stools have been communicated to the MD and that all new orders have been carried out.</p> <p>* Review of the 24 hour Bowel Record to ensure that any resident that is having continuous diarrhea or 3 loose stools in a 24 hour period has MD notification for proper interventions.</p> <p>* Review of all new orders to ensure that the order was properly transcribed into the Electronic Charting System and that the resident received the treatment promptly. The Nurse responsible for receiving the lab/C-diff culture order will enter it into the ECS lab tracking. The Nurse Managers will ensure this is completed during their morning QA review.</p>

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F 157	<p>Continued From page 3 used to treat a bacterial infection.</p> <p>A review of the physician order dated 6/23/14 in part read "Recheck stool for clostridium difficile secondary to persistent diarrhea."</p> <p>A review of the bowel elimination pattern record revealed the following:</p> <ul style="list-style-type: none"> <li>• 6/26/14 "three large loose stools"</li> <li>• 6/29/14 "two medium loose stools"</li> <li>• 6/30/14 "two large loose stools"</li> <li>• 7/5/14 "one medium loose stool"</li> <li>• 7/6/14 "two medium loose stools, one large loose stool"</li> <li>• 7/7/14 "one large loose stool"</li> <li>• 7/8/14 "one small loose stool"</li> </ul> <p>A review of a critical lab result, reported to the nursing facility by the lab provider on 7/8/14 at 6:16 am to Nurse #7 in part read "Critical potassium 2.3." Physician #1 was indicated as notified with a new order received on 7/8/14 at 6:18 am by Nurse #7.</p> <p>A review of a physician telephone order dated 7/8/14 received by Nurse #7 in part read "potassium 20 meq every day."</p> <p>The medication administration record (MAR) did not reflect potassium 20 meq was administered on 7/8/14 as ordered when the nursing facility was notified of a critical potassium level of 2.3 on 7/8/14 at 6:16 am by the lab provider.</p> <p>A review of the nurse's notes dated 7/9/14 at 8:46 pm revealed a stool sample was obtained for C-Diff.</p>	F 157	<p>Review of the lab tracking sheet to ensure that all C-diff cultures were obtained as ordered. The Nurse responsible for receiving the lab order will enter it into The ECS lab tracking.</p> <ul style="list-style-type: none"> <li>* The 2nd shift Supervisor will ensure that all labs/ C-diff cultures obtained are received, distributed to the appropriate responsible nurse, the MD is notified and new orders are transcribed and implemented</li> <li>* The Morning Nurses QA will review all these completed labs/C-diff cultures the following morning to ensure the 2nd shift Supervisor completed the assigned task.</li> <li>* The Lab Company and all Critical Labs will be called to the DON/designee. The DON/designee will ensure that the MD is notified and ensure that any new orders are carried out.</li> <li>* Properly managing the facility staff to ensure proper resident care is provided.</li> </ul> <p>Monitoring for compliance will be at Morning Nurses QA Meeting, all areas listed in #2 will be completed by the Nursing Management Team. The new QA meeting was started on 7/17/14 and monitored by the RVP. During this meeting any discrepancies identified will be documented, investigated, and corrected as required. From any discrepancies identified further education or disciplinary action will occur with the staff responsible for discrepancies. If trends are noted from discrepancies the QA process will be revised by the QA Committee. These new QA programs will be a permanent practice of the facility. This process will be followed by the QA Committee for compliance and revised as required. As discrepancies and trends are identified through the QA audits further educational training will be provided. The facility will contact and setup in-servicing on medication errors and transcription errors with the pharmacist. The facility will involve</p>		

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F 157	<p>Continued From page 4</p> <p>A review of the MAR revealed potassium 20 meq by mouth (15 milliliters) was administered on 7/9/14 at 9:00 am.</p> <p>A review of the nurses' notes from 6/23/14 to 07/09/14 did not reflect any facility care interventions to manage loose stools/diarrhea or the physician or nurse practitioner was consulted for guidance.</p> <p>A review of the bowel elimination pattern record revealed the following:</p> <ul style="list-style-type: none"> <li>7/10/14 "two large loose stools, two medium loose stools"</li> </ul> <p>A review of the lab report received by the nursing facility on 7/10/14 from the lab provider at in part read "Clostridium difficile toxin result positive. Critical results called to, read back and verified with unit manager #1 at 8:20 am."</p> <p>Due to the critical lab reported to the nursing facility on 7/10/14 by the lab provider related to positive C-Diff, the physician ordered Vancomycin 125 mg by mouth four times a day for C-Diff for 14 days. Vancomycin is an antibiotic used to treat bacterial infections.</p> <p>A review of the MAR revealed potassium 20 meq tablet was administered by mouth on 7/10/14 at 9:00 am.</p> <p>A review of the physician order dated 7/10/14; order time not specified, in part read "increase potassium chloride to 20 meq by mouth twice daily." The MAR reflected the resident only received potassium 20 meq once on 7/10/14 at 9:00 am.</p>	F 157	<p>the Medical Director in the facility processes in order to seek guidance and support. A member of the Corporate Office Staff will be on site weekly for at least the next 30 days to assist in support, training, and monitoring of this plan.</p> <p>Compliance is 7/17/14</p>

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F 157	<p>Continued From page 5</p> <p>A review of the lab report received by the nursing facility from the lab provider on 7/11/14 in part read "potassium 2.2 critical level." The MAR reflected potassium 20 meq was administered once at 9:00 am on 7/11, 7/12 and 7/13/14.</p> <p>A review of the lab report received by the nursing facility on 7/14/14 at 2:56 pm from the lab provider reported to Nurse #6 in part read "potassium 2.2 critical level."</p> <p>A review of the physician order dated 7/14/14 pm at 3:00 pm read "give potassium 40 meq now, then increase potassium chloride to 40 meq by mouth twice daily for low potassium." The MAR reflected on 7/14/14 potassium 40 meq was administered "pm" and on 7/15/14, potassium 20 meq (2 tablets) was administered at 9:00 am and 5:00 pm.</p> <p>A review of the lab report received by the nursing facility from the lab provider on 7/16/14 in part read "potassium 2.4." The MAR reflected on 7/16/14 potassium 20 meq (2 tablets) was administered at 9:00 am and 4:00 pm.</p> <p>In an interview on 7/9/14 at 11:42 am, Nurse #2 stated per review of Resident #263's chart and the electronic record she did not see in the medical records, that another stool sample had been attempted or collected to date; ordered to be rechecked by the physician on 6/23/14. UM #1 acknowledged she was responsible for overseeing the nursing unit as the "unit manager." UM #1 indicated a stool sample recheck should have been completed as ordered by the physician, however she could not find where the stool specimen had been completed or</p>	F 157		

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F 157	<p>Continued From page 6 obtain either.</p> <p>In an interview on 7/9/14 at 12:40 pm, the medical director stated he expected the stool sample ordered on 6/23/14 to have been obtained as ordered to reevaluate the resident for continued C-Diff, due to persistent diarrhea, so medical treatment could have been initiated.</p> <p>In an interview on 7/9/14 at 4:21 pm, Nurse #3 and Nurse #4 both acknowledged they reviewed residents' bowel elimination pattern on a daily basis as part of their daily routine. Both nurses indicated they were aware that Resident #263 had completed previous antibiotics (ABT) for C-diff and the resident continued to have loose stools after completion of the ABT (Flagyl) on 6/21/14. They both indicated they did not contact the physician via telephone regarding the continued loose stools, nor had they obtained a second stool sample. Nurse #3 and #4 stated they had no permanent hall assignment and worked throughout the facility</p> <p>In an interview on 7/10/14 at 2:05 pm, Nurse #4 acknowledged she signed the physician order on 6/23/14, which directed to recheck the stool for C-Diff "secondary to persistent diarrhea." Nurse #4 indicated she was aware that a stool sample was needed but she did not obtain a stool sample on her shift because there was no bowel movement. She further stated she did not follow up regarding the order because she assumed the stool specimen had been obtained.</p> <p>In an interview on 7/10/14 at 5:07 pm, UM #1 in the presence of the director of nursing (DON) stated her role was to oversee the nursing unit/nurses to ensure physicians orders were</p>	F 157			

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F 157	<p>Continued From page 7</p> <p>carried out as ordered, UM #1 acknowledged she was aware Resident #263 had completed a course of antibiotics to treat C-Diff (completed on 6/21/14) due to continued diarrhea/loose stools. She stated it was an oversight the stool sample ordered to be obtained on 6/23/14 was not obtained until 7/9/14. The DON added she expected all orders to have been obtained as ordered by the physician and the clinical record to reflect such, if the stool sample was unable to be obtained.</p> <p>In an interview on 7/16/14 at 10:52 am, Nurse #6 acknowledged she worked with Resident #263 on 6/26/14 from 7am-7pm. She stated she recalled the resident having loose stools, moderate amount and she observed loose stools in the resident's brief. She stated NA (nursing assistant) #10 made her aware the resident was having loose stools. She concluded she did not contact the physician regarding the loose stools because the resident was already on contact isolation and "did not appear to have running stool to me."</p> <p>In an interview on 7/16/14 at 11:26 am, NA #8 stated on 7/8/14 Resident #263 had a loose small stool that was "watery, greenish color, with mucous and slimy." She stated she reported her findings to Nurse #3 before she documented as part of her normal routine.</p> <p>In an interview on 7/16/14 at 12:15 pm, NA #10 who worked on 6/26/14 and 6/30/14 stated she observed Resident #263's stools "loose, brownish, and smelled bad." She stated she notified Nurse #6 on 6/26/14 and Nurse #4 on 6/30/14 of her findings.</p> <p>In an interview on 7/16/14 at 12:54 pm, Nurse #7</p>	F 157		



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F 157	<p>Continued From page 8</p> <p>acknowledged on 7/8/14 she worked from 7pm-7am. She stated on occasions she had worked with Resident #263 and recalled the resident's stools having a strong foul odor but could not recall any specific dates. She concluded she did not contact the physician related to the foul odor.</p> <p>In an interview on 7/16/14 at 1:28 pm, Nurse #3 who worked on 7/8/14 from 7am-7pm indicated she checked residents' bowel elimination pattern daily that was put in the computer system by the NAs. She added she was aware that Resident #263 was having continued loose stools. She stated she recalled informing (no date specified) the nurse practitioner (NP) because she (Nurse #3) felt the resident needed an intervention to help with the loose stools. Nurse #3 concluded she did not administer potassium 20 meq during her shift because she was not made aware there was an order to administer potassium on 7/8/14.</p> <p>In an interview on 7/16/14 at 1:53 pm, the medical director indicated he was not made aware by the facility staff the resident was having persistent diarrhea; however he was aware the resident had a history of loose stools and had completed a course of antibiotics for 10 days (Flagyl). He stated on 7/8/14, he ordered for the resident to be given potassium 20 meq every day due to a critical potassium level, however the medication was not administered. He stated he expected the medication to have been administered to the resident on 7/8/14 as ordered, considering the facility staff was aware of the resident critical lab result. He indicated he expected the potassium to have been administered on 7/8/14, because the resident's potassium level was at a critical level and the</p>	F 157			

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F 157	<p>Continued From page 9</p> <p>resident could have had cardiac problems such as an abnormal heart rhythm, while awaiting the potassium to be administered on 7/9/14. On 7/14/14, he indicated the resident required more aggressive treatment in which potassium 40 mg was ordered to be given "now" and then to 40 mg twice daily (total of 80 mg daily) because the potassium level continued to drop. As the medical director, he stated factors which contributed to the low potassium were "Fluid loss as a result of continued loose stools/diarrhea."</p> <p>In an interview on 7/16/14 at 2:23 pm, the DON stated any abnormal stool presentation such as persistent diarrhea, color change or foul odor; she would expect the clinical record to reflect such and the physician or NP to be notified.</p> <p>In an interview on 7/16/14 3:40 pm, the nurse practitioner stated she recalled being informed once (6/23/14) Resident #263 was having continued diarrhea, however did not specifically know who contacted her. The NP stated she ordered for the resident's stool to be re-checked "stool sample" for C-Diff. She added she also informed unit manager #1 of the order and the unit manager responded she would follow up. She stated if she was made aware by the facility Resident #263 had continued to have loose stools/diarrhea, following the order on 6/23/14, she would have ordered an antibiotic, as an intervention to help with the persistent loose stools/diarrhea.</p> <p>In an interview on 7/16/14 at 4:02 pm, the DON indicated her expectation was for the unit manager to have checked the carbon copies of the orders to ensure the physician orders were transcribed properly and carried out. She further</p>	F 157			

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F 157	<p>Continued From page 10</p> <p>stated per her review of the physician orders, the MAR did not reflect that potassium 20 meq was administered as ordered on 7/8/14. She indicated the MAR reflected potassium 20 meq was not administered until 7/9/14 at 9:00 am. The DON added potassium 20 meq was also ordered to be administered on 7/10, 7/11, 7/12, 7/13/14 twice daily and the MAR reflected the medication was administered once each day at 9:00 am. She stated the order to increase potassium was not transcribed into the electronic computer system properly, so the order was not carried out. The DON concluded her expectation was for the unit manager to have checked the carbon copies of the orders to ensure the physician orders were transcribed properly and carried out.</p> <p>In an interview on 7/17/14 at 12:32 pm, the administrator stated the facility process for ensuring physician orders were transcribed correctly as ordered revealed a physician gives an order, the receiving nurse is responsible for ensuring the order is read back for clarity and transcribed into the electronic computer system correctly. She added the unit managers were responsible for following up on new orders daily, to ensure all new orders had been properly transcribed and medications administered as ordered.</p> <p>In an interview on 7/17/14 at 6:55 pm, Nurse #7 who worked 7pm-7am when presented the critical lab result dated 7/8/14 acknowledged she 1) was notified by the lab provider on 7/8/14 at 6:16 am as indicated on the lab report, 2) called the medical director as indicated on the lab report on 7/8/14 at 6:18 am, and received an order from the medical director on 7/8/14 at 6:18 am, to "administer potassium 20 meq every day." She</p>	F 157			

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F 157	<p>Continued From page 11</p> <p>stated that she was suppose to transcribe the order into the electronic computer system for the potassium 20 meq to be administered on 7/8/14, however she mistakenly scheduled it to be administered on 7/9/14. Nurse #7 indicated she did not administer the potassium to Resident #263 on 7/8/14 as ordered nor did she notify the physician. Nurse #7 concluded Nurse #3 who worked on 7/8/14 from 7am-7pm took over the care of Resident #263 after her. Nurse #7 indicated she was not sure if she made her (Nurse #3) aware of the critical potassium level/order received.</p> <p>The administrator was notified of the immediate jeopardy on 7/16/14 at 6:56 pm. The facility provided the following credible allegation on July 17, 2014 at 8:25 pm for F 157 as follows:</p> <p>"RESIDENT IDENTIFIED At the time this IJ was announced R 263-</p> <ul style="list-style-type: none"> <li>· Had a C-diff re-culture on 7/9/10 During the survey</li> <li>· MD was aware of the loose stools 7/9/10 during the survey</li> <li>· The Potassium errors have been resolved as 7/14/14 with correct orders. The MD was notified of errors on 7/16/14 and had gave no changes in the current treatment plan.</li> <li>· The MD is aware of R 263 condition and is monitoring closely.</li> </ul> <p>IDENTIFYING OTHER RESIDENTS AT RISK 1. A 100% Bowel Movement audit was completed from 7/10-7/16/14 to identify any residents that are exhibiting persistent diarrhea/loose stools. The facility printed out the CNA bowel movement charting from the Electronic charting. This audit was completed at</p>	F 157	

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F 157	<p>Continued From page 12</p> <p>9:03 pm on 7/16/14. This task was completed by the Nurse Managers.</p> <ul style="list-style-type: none"> <li>· From this audit R1, R2 and R3 were identified as having a long history of loose stools. The facility notified the MD of these loose stools on 7/16/14 and orders for C-diff cultures were obtained as a safety measure.</li> <li>2. A 100% lab audit was completed for the last 30 days to ensure all labs were obtained and any orders that were received were transcribed and administered as ordered. The Managers printed out all lab orders from the Electronic Charting system to validate this. This was completed by the nurse managers on 7/16/14 at 9:10 pm.</li> <li>· From this audit no further medication errors in relationship to lab results were observed. The facility did note that 13 labs were not drawn per orders in the last 30 days. The MD was notified of these errors and new orders were obtained.</li> <li>3. A 100% in house resident audit was completed to ascertain if all changes of Condition's were identified by nursing and the MD was aware. This audit was completed from 7/14/14-7/16/14 by the Nurse Managers. This was completed on 7/16/14 @ 10:37 PM.</li> <li>· From this audit there were 19 changes of condition that the facility could not find MD notification. The MD was notified of all changes on 7/16/14 by the nurse managers. Upon notification the MD had no new orders or interventions for these residents.</li> <li>4. A 100% MD order audit was completed from 7/10/14-7/16/14 to ensure that all new orders were entered into the Electronic Charting System as ordered. This process was started on 7/16/14 by the nurse managers. This process will continue and will be completed on 7/16/14 by the nurse managers. This audit was completed on 7/17/14 @ 3:35 pm</li> </ul>	F 157		

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F 157	<p>Continued From page 13</p> <ul style="list-style-type: none"> <li>· From this audit 4 med errors were noted. These error for R4- the Metformin was ordered to be held on 7/16/14 and was administered (MD notified and no new received), R5 had multi 2 tabs ordered and 1 tab was transcribed (MD changed to 2 tabs), R6 Facility failed to give Fosamax weekly as ordered for 2 weeks (MD stated to start Fosamax weekly), R7 treatment order of Dry gauze and TAO was ordered 3 times a week and it was transcribed as daily ( MD stated to change to 3 times weekly). None of these residents suffered any Ill effects related to these errors.</li> </ul> <p><b>PROCESSES IMPLEMENTED TO PREVENT FURTHER OCCURRENCES</b></p> <ol style="list-style-type: none"> <li>1. In-servicing for the nursing staff and nursing assistants was started on 7/16/14 by the Nurse Managers. At this point 84 nursing staff and nursing assistants out of 138 have been in-serviced. No member of the nursing staff or nursing assistants will be able to work the floor until they are in serviced.             <ul style="list-style-type: none"> <li>· The facility's Change of Condition Policy and the requirements of MD notification which includes; residents that are experiencing persistent loose stools and have critical potassium levels and other critical/abnormal labs.</li> <li>· The facility's Medication transcription policy which would include the proper transcription of potassium.                 <ol style="list-style-type: none"> <li>a. STARTED ON 7/16/14 AND ONGOING AT THIS TIME.</li> </ol> </li> </ul> </li> <li>2. The Nurse Managers were in-serviced by the Regional Vice President on 7/17/14 on the following:             <ul style="list-style-type: none"> <li>· The Facility's New Morning Nurses QA Meeting which will include:                 <ol style="list-style-type: none"> <li>o Review of the 24 hour condition report to</li> </ol> </li> </ul> </li> </ol>	F 157		

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F 157	Continued From page 14 ensure that all residents that have exhibited persistent loose stools have been communicated to the MD and that all new orders have been carried out. o Review of the 24 hour Bowel Record to ensure that any resident that is having continuous diarrhea or 3 loose stools in a 24 hour period has MD notification for proper interventions. o Review of all new orders to ensure that the order was properly transcribed into the Electronic Charting System and that the resident received the treatment promptly. The Nurse responsible for receiving the lab/C-diff culture order will enter into it into the ECS lab tracking. The Nurse Managers will ensure this is completed during their morning QA review. o Review of the lab tracking sheet to ensure that all C-diff cultures were obtained as ordered. The Nurse responsible for receiving the lab order will enter into it into the ECS lab tracking. o The 2nd shift Supervisor will ensure that all labs/ C-diff cultures obtained are received, distributed to the appropriate responsible nurse, the MD is notified and new orders are transcribed and implemented. o The Morning Nurses QA will review all these completed labs/C-diff cultures the following morning to ensure the 2nd shift Supervisor completed the assigned task. o The Lab Company and all Critical Labs will be called to the DON/designee. The DON/designee will ensure that the MD is notified and ensure that any new orders are carried out. o Properly managing the facility staff to ensure proper resident care is provided.  The Completion date is 7/17/14."  On 7/17/2014 at 8:26 pm, the credible allegation	F 157			

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F 157	Continued From page 15 was validated. Staff interviews with licensed nurses and nursing assistants revealed the facility had implemented the following actions one should take related to 1) physician notification of persistent, continued loose stools or diarrhea, critical potassium level, 2) changes in stools pattern, 3) physician order received for stool sample or specimen to be obtained, 4) change in condition policy, 5) twenty-four hour condition report and 6) process for entering or transcribing new orders in the electronic charting system for medications and labs.	F 157			
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS  The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.  Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.  The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.  The facility must keep confidential all information contained in the resident's records, regardless of	F 164	The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. <b>RESIDENT IDENTIFIED</b> 1. R2 and R167 suffered no ill effects from this citation and no non medical person viewed their medical information. <b>IDENTIFYING OTHER RESIDENTS AT RISK</b> 1. All residents were at risk for this citation. <b>PROCESSES IMPLEMENTED TO PREVENT FURTHER OCCURRENCES</b> 1. Licensed Nurses were in-serviced by Medical Records Coordinator on 8/11/2014 on the following: * The facility's requirement that all resident medical information be protected and remain confidential. *The requirement to close the resident medication administration record when stepping away from the cart. 2. The Management Team were in-serviced by the Corporate Risk Manager on 8/6/14 on the following: *A. HIPPA Privacy Statement - Disclosure of Protected Health Information *B. HIPPA Security Policy and Procedure - Workstation Use	8/20/14	



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F 164	<p>Continued From page 16</p> <p>the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to maintain the privacy of residents' medical information for 2 of 4 residents reviewed for privacy during medication administration (Resident #2, #167). Findings included:</p> <p>1. During a medication pass observation on 7/10/14 at 8:40 am Nurse #10 stated, "I have to go to the refrigerator and I will return." The electronic medication administration record (MAR) was observed opened and completely viewable/readable with medical information for Resident #2 which included the resident's room number, picture, physician, medications (Dilantin, Xalatan) and diagnoses. Nurse #10 returned to the medication cart at 8:45 am. She left the medication cart again at 8:46 am with the computer screen still up, and the resident's medical information visible to anyone passing the cart. The MAR screen automatically closed at 8:49 am. Nurse #10 returned to the medication cart at 8:50 am.</p> <p>On 7/10/14 at 9:50 am Nurse #10 stated, "I was not aware that I left the resident's medical info visible on the computer screen when I departed from the med cart."</p> <p>On 7/10/14 at 4:07 pm, the director of nursing stated she expected the nurses to maintain</p>	F 164	<p>*C. Employees must sign the "Employee Acknowledgement - Workstation Use" statement.</p> <p>4. Monitoring will be completed by Medical Records Clerk, Nursing Managers, and Assigned Guardian Angel. Forms will be discussed daily in Morning QA. Administrator will monitor and review forms weekly x4 weeks and monthly thereafter and report findings to monthly QA Committee.</p> <p>5. Compliance 8/20/14</p>	8/20/14	

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F 164	<p>Continued From page 17</p> <p>privacy of the residents' medical information at all times during med pass, by closing the computer screen or logging off prior to walking away from the med cart.</p> <p>2. During a medication pass observation on 7/10/14 at 9:03 am, Nurse #10 departed from the medication cart with the electronic MAR observed opened and completely viewable/readable with medical information for Resident #167 visible on the computer screen. Nurse #10 entered the resident's room, completely out of sight of the medication cart. The facility staff was observed from the resident door walking by the medication cart. Nurse #10 returned to the medication cart at 9:05 am and the resident's medical information which included the resident's picture, room number, physician, list of medications and diagnoses was still visible on the computer screen. Nurse #10 left from the medication cart at 9:08 am and re-entered Resident #167's room again and administered Zofran (nausea medication) with the MAR still visible and readable to anyone passing the cart. Nurse #10 returned to the medication cart at 9:11 am and the MAR was still visible on the computer screen with the resident's medical information visible.</p> <p>On 7/10/14 at 9:49 am Nurse #10 stated, "I was not aware that I left the resident's medical info visible on the computer screen when I departed from the med cart."</p> <p>On 7/10/14 at 4:07 pm, the director of nursing stated she expected the nurses to maintain privacy of the residents' medical information at all times during med pass, by closing the computer screen or logging off prior to walking away from the med cart.</p>	F 164			

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F 221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to attempt the least restrictive device or provide documentation regarding the medical justification for the physical restraint for 1 of 1 resident (resident #203) reviewed for physical restraints. Findings included:</p> <p>Resident #203 was admitted the facility 5/31/13 with a diagnosis of dementia. The most recent Minimum Data Set (MDS) was a significant change MDS dated 6/3/14 and indicated resident #203 had severe cognitive impairment, required extensive assistance for transfers and was coded for a trunk restraint.</p> <p>In an observation on 7/7/14 at 11:40 AM, resident #203 was observed sitting in a wheelchair with a lap buddy applied to her wheel chair. (A lap buddy is a padded trunk restraint that fits across the front of a wheelchair and is secured to the wheelchair at the arm rest. It prevents the resident from standing unassisted.)</p> <p>In an interview with on 7/7/14 at 12:00 PM, nursing assistant #1 stated that resident #203 could not remove the lap buddy from her wheelchair. The NA stated resident #203 would stand and fall without the lap buddy in place.</p>	F 221	<p>The facility does ensure that each resident has the right to be free from any physical restraints imposed for the purpose of discipline or convenience, and not required to treat the medical symptoms.</p> <p>RESIDENT IDENTIFIED</p> <p>1. R203 had a proper restraint assessment and care plan completed.</p> <p>IDENTIFYING OTHER RESIDENTS AT RISK</p> <p>1. The Restorative team conducted a 100% audit of all residents to gather a comprehensive list of all restraints. To be completed by 8/8/2014.</p> <p>2. The residents identified had a comprehensive audit completed to ensure that all aspects of the restraints process have been completed.(As identified in #1 below). To be completed by 8/20/14.</p> <p>PROCESSES IMPLEMENTED TO PREVENT FURTHER OCCURRENCES</p> <p>1. The Restorative team was in-serviced on 7/31/14 by the Corporate Clinical/OPS on the following:</p> <ul style="list-style-type: none"> <li>*The facilities policy on Restraints.</li> <li>* The need to properly assess each resident before Restraints are implemented.</li> <li>*The need to attempt the least restrictive intervention before a restraint is implemented.</li> <li>* The need to have a reduction plan.</li> <li>*The need to have a proper order which includes medical necessity.</li> <li>*The need to Care Plan the restraint with interventions.</li> </ul> <p>2. The Facility has implemented the policy that "No restraint can be applied without the IDT review"</p> <p>3. The IDT will review each restraint before it is applied to ensure that all components of the policy are present.</p> <p>MONITORING</p> <p>1. The Restorative Nurse will complete the restraint QA and present to the IDT before any restraint is implemented.</p>	8/20/14

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NAME OF PROVIDER OR SUPPLIER  CARVER LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 321 EAST CARVER STREET DURHAM, NC 27704		
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F 221	<p>Continued From page 19</p> <p>In an interview on 7/9/14 at 2:45 PM, nurse #1 stated resident #203 had the lap buddy when she was first admitted into the secured unit. She recalled it was around 6 months ago resident #203 was brought out and placed on the hallway. Nurse #1 stated therapy recently changed her wheelchair to one that was tilted but the lap buddy was not discontinued and it did not fit her wheelchair properly. The lap buddy was now too large for the current wheelchair. She stated they had tried alarms on resident #203 but they did not stop her falls. Nurse #1 confirmed resident #203 last fall was 6/21/14 at 6:20 PM and occurred in resident #203's room. She apparently removed her lap buddy and fell from the wheelchair. The only other fall in the last 6 months was on 4/23/14 at 2:00 AM when resident #203 was discovered on her mat beside her bed. Nurse #1 stated she had not seen resident #203 attempted to remove the lap buddy but had heard reports that she was able to remove it.</p> <p>In an interview on 7/9/14 at 2:55 PM, NA #2 stated she had worked with resident #203 for a long time and as long as she could remember, resident #203 had the lap buddy. Resident #203 was first admitted to the secured unit and had the lap buddy when she was back there. It had never been discontinued since resident #203 was admitted as long as she could remember. Resident #203 was observed at the nurse station. NA #2 requested resident 203 remove her lap buddy but the resident did not respond to the command with any attempt at removal of the device.</p> <p>In an interview on 7/9/14 at 3: 23 PM, the rehabilitation director stated he screened resident</p>	F 221	<p>2. The IDT will review all the components to ensure compliance before the restraint is implemented.</p> <p>3. All facility restraints will have the QA audit completed at least monthly and turned into the Monthly QA committee for review weekly x4 and then monthly and report findings to monthly QA Committee.</p> <p>4. Compliance date 8/20/14</p>	8/20/14

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F 221	Continued From page 20 #203 in April and found no change in her functional status and recommended the lap buddy continued. He recalled at some point resident #203 was put into a tilted wheelchair but he was unsure if her wheelchair was changed out or whether her wheel chair seat just simply tilted because the lap buddy was not the best fit for the wheelchair she was currently sitting in. He stated the lap buddy had been in use for resident #203 as long as he had been working at the facility a year ago.  In an interview on 7/9/14 at 3:45 PM, the director of nursing (DON) stated there should have been attempts at a restraint reduction with documentation supporting the continued need for the lap buddy.  In an interview on 7/10/14 at 12:40 PM, the medical director stated if resident #203 had a lap buddy to her wheelchair, he would have expected the facility to have tried alternatives before using the lap buddy and documented to justification for its continued need.  In an interview on 7/10/14 at 5:00 PM, the administrator stated there should be an attempt at a restraint reduction periodically.	F 221			
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES  The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.	F 242	The facility does ensure that each resident's wishes to get out of bed and eat meals are honored. RESIDENT IDENTIFIED 1. R63 was provided a shower on 7/11/14 IDENTIFYING OTHER RESIDENTS AT RISK 1. The Social Service Department and or The Activity Department will interview each alert and oriented resident on their choice of dining areas and rising time. This will be communicated to the line staff via the KARDEX system by 8/11/14.	8/20/14	

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F 242	<p>Continued From page 21</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed offer or attempt to shower as scheduled for 1 of 1 resident (resident # 63) reviewed for choices. Findings included:</p> <p>Resident #63 was admitted to the facility on 2/26/10 and readmitted 3/8/12 with cumulative diagnoses of encephalopathy and pseudobublar affect (unexplainable emotional episodes). The quarterly Minimum Data Set (MDS) dated 5/24/14 indicated resident #63 had severe cognitive impairment and required total assistance for bathing/shower. The care plan last updated 6/18/14 indicated that resident #63 required assistance with all of her activities of daily living (ADL) to include bathing and showering.</p> <p>A review of the hallway shower list indicated that resident #63 was to receive a shower every Monday and Thursday on first shift.</p> <p>In an observation on 7/7/14 at 1:00 PM, resident #63 was observed in the dining room clean and well groomed. She was dressed for season and no odor was noted.</p> <p>In an observation on 7/9/14 at 10:00 AM, resident #63 was observed sitting up in her wheelchair in her room. She appeared clean and there was no odor noted.</p> <p>In an interview on 7/9/14 at 3:00 PM, nursing assistant (NA) #4 stated resident #63 was assigned a shower every Monday and Thursday on first shift and a bed bath the other days. She</p>	F 242	<p>PROCESSES IMPLEMENTED TO PREVENT FURTHER OCCURRENCES</p> <p>1. The Nursing staff were in-serviced by Adarania C. on 8/11/14 on the following:</p> <ul style="list-style-type: none"> <li>* The facility's new shower sheet</li> <li>* The facility's new shower process</li> <li>* Shower sheets will be turned into the Wound Nurse daily for proper tracking.</li> </ul> <p>2. Nursing Management was in-serviced by the Corporate Clinical/OPS on 8/1/14 on the following:</p> <ul style="list-style-type: none"> <li>*The Wound Nurse/designee will collect the Shower sheets daily while in the facility.</li> <li>* These will be matched against the master shower sheet to ensure that showers were completed.</li> <li>* Any discrepancies observed will result in education/teachable moments of employees.</li> </ul> <p>3. Each department manager has been assigned a resident care area. (Guardian Angel Rounds) Each manager will conduct daily random round observations. During these rounds each manager will ask an alert and oriented resident about their shower routine. Each Manager will complete the new Quality Assurance Monitoring tool.</p> <p>4. Showers will be added to the Topic List for discussion at each Resident Council Meeting.</p> <p><b>MONITORING</b></p> <ol style="list-style-type: none"> <li>1. The new shower system will be a permanent practice of the facility.</li> <li>2. The Wound Nurse/Designee will communicate any discrepancies during the Morning QA meeting. At that time the IDT will revise the plan as needed.</li> <li>3. These Quality Assurance tools will be reviewed daily at the Daily Quality Assurance committee meeting for completeness and accuracy.</li> <li>4. Any discrepancies will be identified and the</li> </ol>

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F 242	Continued From page 22 stated she did not bathe resident #63 on first shift because resident #63 usually gets up so early, the third shift NA already had her up and dressed in the mornings.  In an interview on 7/10/14 at 9:10 AM, NA #5 who worked third shift with resident #63 stated the resident gets up early and she always gave her a bed bath before getting her up into her wheel chair. NA #5 stated she never showered resident #63 on third shift and would expect that first shift to shower her on her assigned shower days and shift.  A review of the ADL records for bathing from 4/1/14 to present revealed resident #63 did not receive a shower on any shift for the time frame stated. There were also no documented refusals of showers from 4/1/14 to present.  In another interview on 7/10/14 at 2:20 PM, NA #4 stated she did not shower resident #63 on first shift today because she assumed third shift showered the resident on third shift last night.  In an interview on 7/10/14 at 2:40 PM, the Director of Nursing stated the 1st shift staff should have showered resident #63 on the assigned shower days or at least offered the resident a shower and documented her responses. If resident #63 refused the shower attempts, the responsible party should have been notified of her refusals.	F 242	Quality Assurance process will be modified as needed. Ongoing staff education, disciplinary action and revision of the Quality Assurance process will occur for discrepancies noted.  5. This Quality Assurance process will continue daily until substantial compliance is obtained and at that time the Quality Assurance committee will review the process weekly x 4 and there after monthly to ensure compliance. The Quality Assurance process will be revised as determined by the Quality Assurance committee.  6. The facility will conduct at least monthly Quality Assurance meetings with the Medical Director to present findings and to seek guidance. The Administrator is responsible for compliance. The facility will be in substantial compliance on 8/20/2014.	8/20/14
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's	F 279	The facility does use the results of the assessment's to develop, review and revise the resident's comprehensive plan of care.	8/20/14

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	<p>Continued From page 23 comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to develop a comprehensive care plan based on the assessed need for range of motion, restorative nursing or splinting services to prevent a further worsening of a known contracture for 1 of 4 resident's (resident #160) reviewed for range of motion. Findings included:</p> <p>Resident #160 was admitted to the facility on 4/27/12 with cumulative diagnoses of left sided hemiplegia, vascular dementia and seizures. The quarterly Minimum Data Set (MDS) dated 6/7/14 indicated resident #160 had severe cognitive impairment and was coded for impairment in range of motion on one side. The annual MDS dated 9/6/13 captured the</p>		<p>RESIDENT IDENTIFIED</p> <ol style="list-style-type: none"> <li>R160 was assessed by therapy for contracture needs and a ROM program was implemented on 7/22/14.</li> <li>R160's plan of care was updated on 8/11/14 to reflect this program.</li> </ol> <p>IDENTIFYING OTHER RESIDENT AT RISK</p> <ol style="list-style-type: none"> <li>All other residents were assessed by Therapy to determine their contracture needs. Residents identified with Restorative/Therapy needs were identified and a formal program was implemented. To be completed by 8/20/14.</li> </ol> <p>PROCESSES IMPLEMENTED TO PREVENT FURTHER OCCURRENCES</p> <ol style="list-style-type: none"> <li>Nursing Management was in-serviced by the Corporate Clinical/OPS on 8/1/14 the following: <ul style="list-style-type: none"> <li>* The Restorative Nurse will ensure that each resident in the facility is: <ol style="list-style-type: none"> <li>Screened by Therapy upon Admission, change of condition and at least Quarterly for Contractures.</li> <li>Any resident needs that are identified are documented, a formal plan is put into place as directive by the Licensed Therapist, staff is communicated this plan and a care plan is derived.</li> </ol> </li> </ul> </li> </ol> <p>MONITORING</p> <ol style="list-style-type: none"> <li>The Restorative Nurse will complete the Contracture QA tool for each new admission and on each residents quarterly MDS schedule to ensure that the resident has been screened by therapy needs are documented and a formalized plan is implemented as recommended.</li> <li>These QA tools will be reviewed at the Morning QA meeting for completeness daily.</li> </ol>	



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F 279	<p>Continued From page 24</p> <p>contracture on the Care Assessment Area (CAA) but it was not care planned but only mentioned as a factor in relation to his need for assistance with his activities of daily living and pain associated with a known contracture. Also, there was no care plan for restorative nursing services of splinting to prevent worsening of the contracture.</p> <p>In an observation on 7/7/14 at 10:58 AM, resident #160 was lying in bed with his left arm flexed at the elbow lying across his chest. The left hand was in a fist position.</p> <p>A review of restorative nursing list for residents receiving ROM and splinting, resident #160 did not appear on the list. On 7/9/14 at 12:12 PM, the director of nursing stated the MDS nurse was over the restorative program which was responsible for ROM and splinting</p> <p>In a group interview on 7/9/14 at 3:05 PM the three restorative aides confirmed that resident #160 was not receiving any passive ROM, active ROM or splinting.</p> <p>In an observation on 7/10/14 at 10:30AM, resident #160 was observed in bed with a rolled wash cloth in his left hand. Nursing assistant #4 stated she washed resident #160's hand and put a clean dry wash cloth inside his hand because the nurse told her too. NA #4 stated she was not told anything about ROM and that restorative normally does the ROM on the residents with contractures.</p> <p>In a telephone interview on 7/10/14 at 11:09 AM, the MDS nurse stated if contractures triggered on the annual assessment as a concern, it should have care planned and restorative or splinting</p>	F 279	<p>3. Findings will be reported to monthly QA Committee and if further discrepancies continue to be identified this plan will be revised by the IDT. The Restorative is responsible for compliance. The facility will be in substantial compliance on 8/20/2014.</p>		

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F 279	Continued From page 25 services provided based on the evaluation.  In an interview on 7/10/14 at 5:00 PM, the DON stated there should have been restorative or splinting services to prevent worsening of resident #160's contracture based on the annual MDS that identified the risk of potential worsening of his contracture.	F 279			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to care plan a restraint for 1 of 1 resident (resident #203)	F 280	1. Resident #203 had a proper restraint assessment by therapy completed on 8/8/14. MDS care plan updates in process will be completed by 8/20/14. Lap Buddy has been removed. 2. The Restorative Team conducted a 100% audit of all Residents and gathered a comprehensive list of all restraints. The Residents identified had a comprehensive audit completed to ensure that all aspects of the restraint process have been completed by 8/20/14. 3. To prevent further occurrences the Restorative team was in serviced on 7/31/14 by the Corporate Clinical/OPS VP on the following: The facility policy on restraints, the need to properly assess each resident before a restraint is implemented, the need to attempt the least restrictive intervention before a restraint is implemented, the need to have a restraint reduction plan in place, have a proper order which includes medical necessity, and a care plan with specific interventions that are resident specific. Facility has implemented, "No restraint will be applied without the IDT review". The IDT will review each restraint before it is applied to ensure that all components of the policy are present.	8/20/14	

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F 280	<p>Continued From page 26</p> <p>reviewed for physical restraints. Findings included:</p> <p>Resident #203 was admitted the facility 5/31/13 with a diagnosis of dementia. The most recent Minimum Data Set (MDS) was a comprehensive significant change dated 6/3/14 indicated resident #203 had severe cognitive impairment, required extensive assistance for transfers and was coded for a trunk restraint. The Care Assessment Area (CAA) stated 6/3/14 indicated resident #203 required the lap buddy to prevent rising. Resident #203 was unable to remove the device at will or on command. A care plan was to be developed.</p> <p>A review of the care plan updated at the time of the comprehensive significant change assessment dated 6/2/14 did not include a care plan for the lap buddy with interventions specific for a restraint. The fall care plan did not include the lap buddy except for a mention of it 's presence on 10/11/13 and 11/11/13 involving a falls from her wheelchair.</p> <p>In an observation on 7/7/14 at 11:40 AM, resident #203 was observed sitting in the dining room in a wheelchair with a lap buddy applied to her wheel chair. (A lap buddy is a padded trunk restraint that fits across the front of a wheelchair and is secured to the wheelchair at the arm rest. It prevents the resident from standing unassisted.)</p> <p>In an interview with on 7/7/14 at 12:00 PM, nursing assistant #1 stated that resident #203 could not remove the lap buddy from her wheel chair. The NA stated resident #203 would stand and fall without the lap buddy in place. NA #1 stated the lap buddy was removed and resident #203 toileted every 2 hours the lap buddy was to</p>	F 280	<p>continued.</p> <p>4. Monitoring will be accomplished by the Restorative Nurse completing the restraint QA and present it to the IDT before any restraint is implemented. The IDT will review all the components to ensure compliance before the restraint is implemented. All facility restraints will have a QA audit completed and presented to Morning QA daily for 4 weeks and monthly then and findings reviewed at the Monthly QA Committee.</p> <p>5. Compliance will be 8/20/14</p>	8/20/14	

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F 280	<p>Continued From page 27</p> <p>be reapplied unless she was going to lay the resident in the bed.</p> <p>In an interview on 7/9/14 at 12:12 PM, the director of nursing (DON) stated the lap buddy had been in use for resident #203 as long as she had had been employed at the facility. The DON stated the lap buddy should be removed and the resident repositioned at least every 2 hours and taken off the resident during meals. She stated she thought the lap buddy was care planned with all the specific interventions.</p> <p>In an interview on 7/9/14 at 2:55 PM, resident #203 was observed at the nurse station. NA #2 requested resident 203 remove her lap buddy but the resident did not respond to the command with any attempt at removal of the device.</p> <p>In an interview on 7/9/14 at 3: 23 PM, the rehabilitation director stated he screened resident #203 in April and found no change in her functional status and recommended the lap buddy continued. He stated any restraint should be care planned and periodically reviewed for continued need.</p> <p>In a telephone interview on 7/10/14 at 10:50 AM, the MDS nurse stated if she completed a CAA specific for the restraint on resident #203, there should have been a care plan done as well. She stated she must have neglected to complete one.</p> <p>In an interview on 7/10/14 at 5:00 PM, the administrator stated there should be a care plan telling the staff how the lap buddy was to be utilized and evaluated to determine to continued need.</p>	F 280			

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F 281 F 281 SS=D	Continued From page 28 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to obtain an physician order for a physical restraint for 1 of 1 residents (resident #203) reviewed for physical restraints. Findings included:  The facility policy dated 2/5/14 indicated a written physician order must be obtained for a physical restraint.  Resident #203 was admitted into the facility on 5/31/13 with a diagnosis of dementia. The most recent Minimum Data Set was a significant change dated 6/3/14 which indicated resident #203's mental status was severely impaired. The resident required extensive assistance with transfers and was coded for a trunk restraint.  A review of the medical record to include thinned documentation revealed no physician's order for a physical restraint.  In an observation on 7/7/14 at 11:40 AM, resident #203 was observed in the dining room sitting in a wheelchair with a lap buddy applied to her wheel chair. (A lap buddy is a padded trunk restraint that fits across the front of a wheelchair and is secured to the wheelchair at the arm rest. It prevents the resident from standing unassisted.)	F 281 F 281	1. Resident #203 had a proper restraint assessment and care plan completed. Physician order obtained on 7/17/14 to d/c lap buddy restraint. Resident with chair alarm and monitor for fall prevention. 2. The Restorative team conducted a 100% audit of all residents to gather a comprehensive list of all restraints. This was completed 8/8/14 The residents identified had a comprehensive audit completed to ensure that all aspects of the restraint process have been completed. Completion will be 8/20/14. 3. To prevent further occurrences the Restorative team was in-serviced on 7/31/14 by the Corporate Clinical/OPS VP on the following: Facility policy on restraints, the need to properly assess each resident before restraints are implemented, the need to attempt the least restrictive intervention before a restraint is implemented, the need to have a reduction plan, the need to have a proper order which includes medical necessity, and the need to care Plan the restraint with resident specific interventions. The facility has implemented the policy that "No restraint can be applied without the IDT review". The IDT will review each restraint before it is applied to ensure all components of the policy are present. 4. The Restorative Nurse will ensure compliance and will complete the restraint QA and present it to the IDT before any restraint is implemented. The IDT will review all components to ensure compliance before the restraint is implemented. All facility restraints will have a QA audit completed and reviewed at Daily QA x4 weeks	8/20/14	

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F 281	<p>Continued From page 29</p> <p>In an interview on 7/7/14 at 12:00 PM, nursing assistant #1 stated that resident #203 could not remove the lap buddy from her wheel chair. The NA stated resident #203 would stand and fall without the lap buddy in place.</p> <p>In an interview on 7/9/14 at 12:12 PM, the director of nursing (DON) stated the physical restraint had been in use for resident #203 as long as she had had been employed at the facility but she was unable to locate the written order for the device.</p> <p>In an interview on 7/9/14 at 2:45 PM, nurse #1 stated resident #203 had the lap buddy when she was first admitted into the secured unit. She recalled it was around 6 months ago when resident #203 was transferred from the secure unit and placed on the hallway. Nurse #1 stated she had not seen resident #203 attempted to remove the lap buddy but had heard reports that she was able to remove it.</p> <p>In an interview on 7/9/14 at 3:23 PM, the rehabilitation director stated he screened resident #203 in April and found no change in her functional status and recommended the lap buddy continued. He stated the lap buddy was in use when he started his employment a year ago. He stated he assumed there was an order for the device.</p> <p>In an interview on 7/10/14 at 12:40 PM, the medical director stated if resident #203 had a lap buddy to her wheel chair, he would have given a verbal or written order for the device.</p> <p>In an interview on 7/10/14 at 5:00 PM, the administrator stated her expectation of a physician order supporting why a physical</p>	F 281	and monthly afterwards. Findings to be presented to monthly QA Committee. 5. Compliance 8/20/14	8/20/14	

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F 281	Continued From page 30	F 281			
F 309 SS=J	<p>restraint was necessary for any resident.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff, physician and nurse practitioner interviews, the facility failed to manage the care of a resident by failure to obtain or re-check a stool sample as ordered by the physician for persistent diarrhea, that resulted in a 17 day delay in medical treatment because the physician was not notified. As a result of continued loose stools, the resident experienced low blood pressures and a fluid volume deficit (loss of bodily fluids), which lead to a low potassium level. The facility also failed to administer potassium as ordered by the physician for a critical potassium level of 2.3 (3.5 - 5.3 reference range) for 1 of 2 residents' records reviewed for Clostridium Difficile (C-Diff) (Resident #263).</p> <p>The immediate jeopardy began on 6/23/14 when a stool specimen was not obtained as ordered by the physician to recheck stool for C-Diff due to persistent diarrhea. The immediate jeopardy was removed on 7/17/14 at 8:47 pm when the facility provided an implemented an acceptable credible</p>	F 309	<p>1. Resident #263 had a C-Diff re-cultured on 7/9/14 during the survey. MD was made aware of loose stools on 7/9/14 during survey. The Potassium errors have been resolved as of 7/14/14 with correct orders. The MD was notified of errors on 7/16/14 and had gave no changes in the current treatment plan. The MD is aware of resident #263 condition and is monitoring closely.</p> <p>2. A 100% bowel movement audit was completed from 7/10-7/16/14 to identify any residents that are exhibiting persistent diarrhea/ loose stools. The facility printed out the CNA bowel movement charting from the electronic charting system. This audit was completed at 9:03 pm on 7/16/14. This task was completed by Nurse Managers. From this audit 3 residents were identified as having a long history of loose stools. The facility notified MD on 7/16/14 and orders for C-diff cultures were obtained as a precautionary measure. A 100% lab audit was completed for the last 30 days to ensure all labs were obtained and any orders that were received were transcribed and administered as ordered. The Managers printed out all lab orders from the Electronic Charting System to validate the orders. This was completed on 7/16/14 at 9:10 pm. From this audit no further medication errors in relationship to lab results were found. The facility did note that 13 labs were not drawn per orders in the last 30 days. The MD was notified of these errors and new orders were obtained. A 100% in house Resident audit was completed to ascertain if all Changes in Condition were identified by nursing and</p>	7/17/14	

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F 309	<p>Continued From page 31</p> <p>allegation of compliance. The facility will remain out of compliance at a scope and severity of D (no actual harm with the potential for more than minimal harm) that is not immediate jeopardy to ensure monitoring systems put in place are effective. Findings included:</p> <p>Resident #263 was admitted into the facility on 4/28/14. Diagnoses included C-Diff ( a type of infectious diarrhea), diarrhea, hypokalemia (low potassium), hypertension, debility (physical weakness), ventriculostomy (an external catheter placed in the ventricles of the brain to drain cerebral spinal fluid) clamped, cerebral aneurysm (area that has become weakened causing the blood vessels in the brain to bulge), dysphagia (difficult swallowing), difficulty walking and general muscle weakness. The admission Minimum Data Set completed on 5/9/14 indicated Resident #263 had short and long term memory problems. Decision making was listed as moderately impaired.</p> <p>Lexi-Comp's Geriatric Dosage Handbook, 17th edition in part reads "potassium is the major cation (causes a positive charge) of intracellular (located or occur within the cell) fluid and is essential for conduction of nerve impulses in heart, brain and skeletal muscle; contraction of cardiac, skeletal and smooth muscles; maintenance of normal renal (kidney) function, acid-base balance, carbohydrate metabolism, and gastric (stomach) secretion."</p> <p>A review of the April 2014 admission monthly physician orders revealed Resident #263 was not prescribed potassium on admission into the facility. Medications that related to heart/blood pressure included:</p>	F 309	<p>continued.</p> <p>the MD was made aware. This audit was completed from 7/14-7/16/14 by the Nurse Managers.. this was completed on 7/16/14 at 10:37 pm. From this audit there were 19 changes in condition that the facility could not find the MD notification. The MD was notified of all changes on 7/16/14 by the Nurse Managers. Upon notification the MD had no new orders or interventions for these Residents. A 100% MD order audit was completed from 7/10-7/16/14 to ensure that all orders were entered into the Electronic System as ordered. This audit was completed on 7/17/14 at 3:35 pm. From this audit 4 medication errors were noted These errors were for, Metformin was to be held on 7/16/14 and was administered. MD notified and no new order given. Multi tab ordered for 1 tab and 2 were given. MD changed order to 2 tabs. Facility failed to give Fosamax weekly as ordered for 2 weeks. MD changed order to start Fosamax weekly. Treatment order for Dry Gauze and TAO was ordered 3 times a week and it was transcribed as daily. MD changed order to 3 times weekly. None of the Residents suffered any ill effects related to these errors.</p> <p>3. In-servicing for the nursing staff and nursing assistants was started on 7/16/14 by Nurse Managers. In services included, Facility's Change in Condition Policy and the requirements of MD notification which includes; Resident's that are experiencing persistent loose stools and have critical potassium levels and other critical/abnormal labs. The facility's Medication transcription policy was reviewed with nurses to include proper transcription of potassium and other medications. The Nurse</p>	7/17/14	



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F 309	<p>Continued From page 32</p> <ul style="list-style-type: none"> <li>· Aspirin 325 milligram (mg) by mouth daily</li> <li>· Lisinopril 5 mg by mouth daily</li> </ul> <p>A review of the lab report received by the nursing facility from the lab provider on 5/13/14 revealed a potassium level of 3.6.</p> <p>A review of the lab report received by the nursing facility on 6/12/14 from the lab provider in part read "clostridium difficile toxin result positive." It was further indicated that the report was "Read back and verified with the director of nursing at 8:55 am."</p> <p>A review of the physician order dated 6/12/14 read "Flagyl 500 mg by mouth three times daily for clostridium difficile for 10 days." The medication administration record (MAR) reflected the last dose of Flagyl was administered on 6/21/14 at 10:00 pm. Flagyl is an antibiotic that is used to treat a bacterial infection.</p> <p>A review of the nurses' notes revealed the following blood pressures:</p> <ul style="list-style-type: none"> <li>· 6/21/14 (128/70) at 10:53 pm</li> <li>· 6/21/14 (126/68) at 10:54 pm</li> </ul> <p>A review of the physician order dated 6/23/14 in part read "Recheck stool for clostridium difficile secondary to persistent diarrhea."</p> <p>A review of the nurses' notes on 6/23, 6/24, 6/25, 6/26/14, did not reflect an attempt to collect a stool specimen, facility care interventions to manage loose stools/diarrhea or the physician or nurse practitioner was consulted for guidance.</p>	F 309	<p>continued</p> <p>Managers were in serviced by the Regional Vice President on 7/17/14 on the following: the facility's new morning nurses QA meeting to include: review of 24 hour condition report to ensure that all Residents that have exhibited persistent loose stools have been communicated to the MD and new orders have been carried out. Review the 24 hour Bowel Record to ensure that any Resident that is having continuous diarrhea or 3 loose stools in a 24 hour period has MD notification for proper interventions. Review all new orders to ensure that the order was properly transcribed into the Electronic Charting System and that the Resident received the treatment promptly. The Nurse responsible for receiving the lab/C-diff culture order will enter it into the ECS lab tracking. The 2nd shift Supervisor will ensure all labs/C-diff cultures obtained are received, distributed to the appropriate responsible nurse, the MD is notified and new orders are transcribed and implemented. The Morning Nurses QA will review all these completed labs/C-diff cultures the following morning to ensure the 2nd shift Supervisor completed the assigned tasks. The Lab Company and all Critical Labs will be called to the DON/designee. The DONB/designee will ensure that the MD is notified and ensure that any new orders are carried out timely.</p> <p>4. During the morning nurses QA meeting all areas listed in #2 will be completed by the Nurse Management Team. This new QA meeting was started on 7/17/14 and</p>	7/17/14	

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F 309	<p>Continued From page 33</p> <p>A review of the bowel elimination pattern record revealed the following:</p> <ul style="list-style-type: none"> <li>6/26/14 "three large loose stools"</li> </ul> <p>A review of the nurses' notes on 6/27, 6/28, 6/29/14 did not reflect an attempt to collect a stool specimen, facility care interventions to manage loose stools/diarrhea or the physician or nurse practitioner was consulted for guidance.</p> <p>A review of the bowel elimination pattern record revealed the following:</p> <ul style="list-style-type: none"> <li>6/29/14 "two medium loose stools"</li> <li>6/30/14 "two large loose stools"</li> </ul> <p>A review of the nurse's notes on 6/30, 7/1, 7/2, 7/3/14 did not reflect an attempt to collect a stool specimen, facility care intervention to manage loose stools/diarrhea or the physician or nurse practitioner was consulted for guidance.</p> <p>A review of the nurse's note revealed the following blood pressure:</p> <ul style="list-style-type: none"> <li>7/3/14 (108/64) at 2:47 am</li> </ul> <p>A review of the MAR reflected Resident #263 received Lisinopril 5 mg by mouth daily at 9:00 am on 7/1, 7/2, 7/3, 7/4, 7/5 and 7/6/14. The order was indicated as discontinued on 7/6/14. Lisinopril is a medication used to treat conditions such as high blood pressure and congestive heart failure. An action of Lisinopril is that it functions to decrease certain chemicals that tighten the blood vessels, thus allowing the blood to flow more smoothly.</p>	F 309	<p>continued</p> <p>was monitored by the RVP. During these meetings any discrepancies identified will be documented, investigated, and corrected as required. From any discrepancies identified further education or disciplinary action will occur with staff members responsible. If trends are noted this QA process will be revised by the QA Committee. These new QA programs will be a permanent practise of the facility. This QA process will be followed by the QA committee for compliance and revisions if needed. As trends are identified through these QA audits further educational and training will be provided. The facility will contact and set up in servicing on medication errors and transcription with the Pharmacist. The facility will continue to involve the Medical Director in the facility processes in order to seek guidance and support. A member of the Home Office staff will be on site weekly for the next 30 days to offer guidance, support, and training and monitoring of this plan. All findings will be presented to the monthly QA committee meeting.</p> <p>5. Compliance is 7/17/14.</p>	7/17/14	

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F 309	<p>Continued From page 34</p> <p>A review of the bowel elimination pattern record revealed the following:</p> <ul style="list-style-type: none"> <li>7/5/14 "one medium loose stool"</li> <li>7/6/14 "two medium loose stools, one large loose stool"</li> </ul> <p>A review of the nurse's notes on 7/4, 7/5, 7/6 7/7/14 did not reflect an attempt to collect a stool specimen, facility care intervention to manage loose stools/diarrhea or the physician or nurse practitioner was consulted for guidance.</p> <p>A review of the bowel elimination pattern record revealed the following:</p> <ul style="list-style-type: none"> <li>7/7/14 "one large loose stool"</li> </ul> <p>A review of the nurse's note revealed the following blood pressure:</p> <ul style="list-style-type: none"> <li>7/7/14 (109/65) at 4:42 am</li> </ul> <p>A review of the nurses' note revealed the following blood pressure:</p> <ul style="list-style-type: none"> <li>7/7/14 (111/57) at 5:51 pm</li> </ul> <p>A review of the bowel elimination pattern record revealed the following:</p> <ul style="list-style-type: none"> <li>7/8/14 "one small loose stool"</li> </ul> <p>A review of a critical lab result, reported to the nursing facility by the lab provider on 7/8/14 at 6:16 am to Nurse #7 in part read "Critical potassium 2.3." Physician #1 was indicated as notified with a new order received on 7/8/14 at 6:18 am by Nurse #7.</p>	F 309			

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F 309	Continued From page 35  A review of a physician telephone order dated 7/8/14 received by Nurse #7 in part read "potassium 20 milliequivalent (meq) every day."  The MAR did not reflect that potassium 20 (meq) was administered on 7/8/14 as ordered when the nursing facility was notified of a critical potassium level of 2.3 on 7/8/14 at 6:16 am by the lab provider.  A review of the nurse's note revealed the following blood pressure:  · 7/8/14 (98/58) at 7:02 pm  A review of the nurses' notes on 7/8, and 7/9/14 did not reflect an attempt to collect a stool specimen, facility care interventions to manage loose stools/diarrhea or the physician or nurse practitioner was consulted for guidance.  A review of the nurse's note revealed the following blood pressure:  · 7/9/14 (98/58) at 6:10 am  A review of the MAR revealed that potassium 20 meq by mouth (15 milliliters) was administered on 7/9/14 at 9:00 am.  A review of the nurses' notes revealed the following blood pressures:  · 7/9/14 (95/54) at 5:12 pm · 7/9/14 (100/54) at 8:46 pm  A review of the nurse's notes dated 7/9/14 at 8:46 pm revealed a stool sample was obtained for	F 309			

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F 309	<p>Continued From page 36 C-Diff.</p> <p>A review of the bowel elimination pattern record revealed the following:</p> <ul style="list-style-type: none"> <li>7/10/14 "two large loose stools, two medium loose stools"</li> </ul> <p>A review of the lab report received by the nursing facility on 7/10/14 from the lab provider at in part read "clostridium difficile toxin result positive. Critical results called to, read back and verified with unit manager #1 at 8:20 am."</p> <p>Due to the critical lab reported to UM #1 on 7/10/14 at 8:20 am by the lab provider related to positive C-Diff, the physician ordered Vancomycin 125 mg by mouth four times a day for C-Diff for 14 days (Vancomycin is an antibiotic used to treat bacterial infections), and potassium chloride 20 meq twice daily for low potassium.</p> <p>A review of the physician order dated 7/10/14; order time not specified, in part read "increase potassium chloride to 20 meq by mouth twice daily." The MAR reflected the resident only received potassium 20 meq once on 7/10/14 at 9:00 am.</p> <p>A review of the lab report received by the nursing facility from the lab provider on 7/11/14 in part read "potassium 2.2 critical level." The MAR reflected that potassium 20 meq was administered once at 9:00 am on 7/11, 7/12 and 7/13/14.</p> <p>A review of the lab report received by the nursing facility on 7/14/14 at 2:56 pm from the lab provider reported to Nurse #6 in part read</p>	F 309			

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F 309	<p>Continued From page 37 "potassium 2.2 critical level."</p> <p>A review of the physician order dated 7/14/14 pm at 3:00 pm read "give potassium 40 meq now, then increase potassium chloride to 40 meq by mouth twice daily for low potassium." The MAR reflected on 7/14/14 that potassium 40 meq was administered "pm" and on 7/15/14, potassium 20 meq (2 tablets) was administered at 9:00 am and 5:00 pm.</p> <p>A review of the lab report received by the nursing facility from the lab provider on 7/16/14 in part read "potassium 2.4." The MAR reflected that on 7/16/14 potassium 20 meq (2 tablets) was administered at 9:00 am and 4:00 pm.</p> <p>In an interview on 7/9/14 at 11:42 am, Nurse #2 and unit manager (UM) #1 were asked about the results of the stool sample ordered to be rechecked by the physician on 6/23/14. Nurse #2 stated per review of Resident #263's chart and the electronic record she did not see another stool sample had been attempted or collected to date. UM #1 indicated a stool sample recheck should have been completed as ordered by the physician, however she could not find where the stool specimen had been completed or obtain.</p> <p>In an interview on 7/9/14 at 12:40 pm, the medical director stated he expected the stool sample ordered on 6/23/14 to have been obtained as ordered to reevaluate the resident for continued C-Diff, due to persistent diarrhea, so medical treatment could have been initiated.</p> <p>In an interview on 7/9/14 at 4:21 pm, Nurse #3 and Nurse #4 both acknowledged they reviewed residents' bowel elimination pattern on a daily</p>	F 309			

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F 309	<p>Continued From page 38</p> <p>basis as part of their daily routine. Both nurses acknowledged they were aware Resident #263 had completed previous antibiotics (ABT) for C-diff and the resident continued to have loose stools after completion of the ABT (Flagyl) on 6/21/14. They both indicated they did not contact the physician via telephone regarding the continued loose stools, nor had they obtained a second stool sample. Both nurses stated they had no permanent hall assignment and worked throughout the facility.</p> <p>In an interview on 7/10/14 at 2:05 pm, Nurse #4 acknowledged she signed the physician order on 6/23/14, which directed to recheck the stool for C-Diff "secondary to persistent diarrhea." Nurse #4 indicated she was aware a stool sample was needed but she did not obtain a stool sample on her shift because there was no bowel movement. She further stated she did not follow back up regarding the order because she assumed the stool specimen had been obtained.</p> <p>In an interview on 7/10/14 at 5:07 pm, the DON stated she expected all orders to have been obtained as ordered by the physician and the clinical record to reflect such, if the stool sample was unable to be obtained.</p> <p>In an interview on 7/16/14 at 10:52 am, Nurse #6 acknowledged she worked with Resident #263 on 6/26/14 from 7am-7pm. She stated she recalled the resident having loose stools, moderate amount and observed loose stools in the resident's brief. She stated NA (nursing assistant) #10 made her aware the resident was having loose stools. She concluded she did not contact the physician regarding the loose stools because the resident was already on contact isolation and</p>	F 309			

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F 309	<p>Continued From page 39</p> <p>"did not appear to have running stool to me."</p> <p>In an interview on 7/16/14 at 11:26 am, NA #8 stated on 7/8/14 Resident #263 had a loose small stool described as "watery, greenish color, with mucous and slimy." She stated she reported her findings to Nurse #3 before she documented as part of her normal routine.</p> <p>In an interview on 7/16/14 at 12:15 pm, NA #10 who worked on 6/26/14 and 6/30/14 stated she observed Resident #263 's stools "loose, brownish, and smelled bad." She stated she notified Nurse #6 on 6/26/14 and Nurse #4 on 6/30/14 of her findings.</p> <p>In an interview on 7/16/14 at 12:54 pm, Nurse #7 acknowledged on 7/8/14 from 7pm-7am she received a critical potassium lab result via telephone; however she was not the primary nurse and thought she conveyed the critical lab (potassium) to Nurse #3. Nurse #7 stated on occasions she had worked with Resident #263 and recalled her stools having a strong foul odor but could not recall any specific dates. She concluded she did not contact the physician related to the foul odor, nor did she administer potassium 20 meq to the resident.</p> <p>In an interview on 7/16/14 at 1:28 pm, Nurse #3 who was the primary nurse on 7/8/14 from 7am-7pm indicated she checked residents' bowel elimination pattern daily that was put in the computer system by the NAs. She added she was aware Resident #263 was having continued loose stools. She stated she recalled informing (no date specified) the nurse practitioner (NP) because she (Nurse #3) felt the resident needed an intervention to help with the loose stools.</p>	F 309			



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F 309	<p>Continued From page 40</p> <p>Nurse #3 concluded she did not administer potassium 20 meq during her shift because she was not made aware there was an order to administer potassium on 7/8/14.</p> <p>In an interview on 7/16/14 at 1:53 pm, the medical director stated he became aware of the critical potassium level on 7/8/14 "early morning" and ordered for potassium 20 meq to be administered due to the critical lab. He stated he expected the medication to have been administered to the resident on 7/8/14 as ordered, considering the facility staff was aware of the resident critical lab result. He indicated he expected the potassium to have been administered on 7/8/14, because the resident's potassium level was at a critical level and the resident could have had cardiac problems such as an abnormal heart rhythm, while awaiting the potassium to be administered on 7/9/14. He stated on 7/14/14 the resident required more aggressive treatment in which potassium 40 mg was ordered to be given "now" and then to 40 mg twice daily (total of 80 mg daily) because the potassium level continued to drop. As the medical director, he stated factors which contributed to the low potassium were "fluid loss as a result of continued loose stools/diarrhea." The medical director concluded he was not made aware by the facility staff the resident was having persistent diarrhea, however he was aware the resident had a history of loose stools and had completed a course of antibiotics for 10 days (Flagyl).</p> <p>In an interview on 7/16/14 at 2:23 pm, the DON stated any abnormal stool presentation such as persistent diarrhea, color change or foul odor; she expected the clinical record to reflect such and the physician or NP to be notified.</p>	F 309			

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F 309	<p>Continued From page 41</p> <p>In an interview on 7/16/14 3:40 pm, the nurse practitioner stated she recalled being informed once (6/23/14) the resident was having continued diarrhea, however did not specifically know who contacted her. The NP stated she entered an order for the resident's stool to be re-checked "stool sample" for C-Diff. She added she also informed unit manager #1 of the order and the unit manager responded she would follow up. She stated if she was made aware by the facility related to Resident #263 continued to have loose stools/diarrhea, following the order on 6/23/14, she would have ordered an antibiotic, as an intervention to help with the persistent loose stools/diarrhea.</p> <p>In an interview on 7/16/14 at 4:02 pm, the DON stated per her review of the physician orders, the MAR did not reflect potassium 20 meq was administered as ordered on 7/8/14. She indicated the MAR reflected potassium 20 meq was not administered until 7/9/14 at 9:00 am. The DON added potassium 20 meq was also ordered to be administered on 7/10, 7/11, 7/12, 7/13/14 twice daily and the MAR reflected the medication was administered once each day at 9:00 am. She stated the order to increase potassium was not transcribed into the electronic computer system properly, so the order was not carried out. The DON concluded her expectation was for the unit manager to have checked the carbon copies of the orders to ensure the physician orders were transcribed properly and carried out.</p> <p>In an interview on 7/16/14 at 6:17 pm, the medical director stated Lisinopril 5 mg by mouth daily was discontinued on 7/6/14 due to the resident's low blood pressures. He stated</p>	F 309			

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F 309	<p>Continued From page 42</p> <p>"persistent loose stools/diarrhea was causing the blood pressure to drop."</p> <p>In an interview on 7/17/14 at 12:32 pm, the administrator stated when a physician gives an order, the receiving nurse is responsible for ensuring the order is read back for clarity and transcribed into the electronic computer system correctly. She added the unit managers were responsible for following up on new orders daily, to ensure all new orders had been properly transcribed and medication administered as ordered.</p> <p>In an interview on 7/17/14 at 6:55 pm, Nurse #7 who worked from 7pm-7am when presented the critical lab result dated 7/8/14 acknowledged she 1) was notified by the lab provider on 7/8/14 at 6:16 am as indicated on the lab report, 2) called the medical director as indicated on the lab report on 7/8/14 at 6:18 am, and received an order from the medical director on 7/8/14 at 6:18 am, to "administer potassium 20 meq every day." She stated she was suppose to transcribe the order into the electronic computer system for the potassium 20 meq to be administered on 7/8/14, however she mistakenly scheduled it to be administered on 7/9/14. She concluded she did not administer the potassium to Resident #263 on 7/8/14 as ordered. Nurse #7 concluded Nurse #3 who worked on 7/8/14 from 7am-7pm took over the care of Resident #263 after her. Nurse #7 indicated she was not sure if she made her (Nurse #3) aware of the critical potassium level/order received.</p> <p>The administrator was notified of the Immediate Jeopardy on 7/16/14 at 6:56 pm. The immediate jeopardy was removed on 7/17/14 at 8:47 pm</p>	F 309			

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F 309	<p>Continued From page 43</p> <p>when the facility provided an acceptable credible allegation on July 17, 2014 at 8:25 pm for F 309 as follows:</p> <p>"RESIDENT IDENTIFIED</p> <p>At the time this IJ was announced R 263-</p> <ul style="list-style-type: none"> <li>· Had a C-diff re-culture on 7/9/10 During the survey</li> <li>· MD was aware of the loose stools 7/9/10 during the survey</li> <li>· The Potassium errors have been resolved as 7/14/14 with correct orders. The MD was notified of errors on 7/16/14 and had gave no changes in the current treatment plan.</li> <li>· The MD is aware of R 263 condition and is monitoring closely.</li> </ul> <p>IDENTIFYING OTHER RESIDENTS AT RISK</p> <ol style="list-style-type: none"> <li>1. A 100% Bowel Movement audit was completed from 7/10-7/16/14 to identify any residents that are exhibiting persistent diarrhea/loose stools. The facility printed out the CNA bowel movement charting from the Electronic charting. This audit was completed at 9:03 pm on 7/16/14. This task was completed by the Nurse Managers. <ul style="list-style-type: none"> <li>· From this audit R1, R2 and R3 were identified as having a long history of loose stools. The facility notified the MD of these loose stools on 7/16/14 and orders for C-diff cultures were obtained as a safety measure.</li> </ul> </li> <li>2. A 100% lab audit was completed for the last 30 days to ensure all labs were obtained and any orders that were received were transcribed and administered as ordered. The Managers printed out all lab orders from the Electronic Charting system to validate this. This was completed by the nurse managers on 7/16/14 at 9:10 pm. <ul style="list-style-type: none"> <li>· From this audit no further medication errors</li> </ul> </li> </ol>	F 309			

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F 309	<p>Continued From page 44</p> <p>in relationship to lab results were observed. The facility did note that 13 labs were not drawn per orders in the last 30 days. The MD was notified of these errors and new orders were obtained.</p> <p>3. A 100% in house resident audit was completed to ascertain if all changes of Condition 's were identified by nursing and the MD was aware. This audit was completed from 7/14/14-7/16/14 by the Nurse Managers. This was completed on 7/16/14 @ 10:37 PM.</p> <ul style="list-style-type: none"> <li>From this audit there were 19 changes of condition that the facility could not find MD notification. The MD was notified of all changes on 7/16/14 by the nurse managers. Upon notification the MD had no new orders or interventions for these residents.</li> </ul> <p>4. A 100% MD order audit was completed from 7/10/14-7/16/14 to ensure that all new orders were entered into the Electronic Charting System as ordered. This process was started on 7/16/14 by the nurse managers. This process will continue and will be completed on 7/16/14 by the nurse managers. This audit was completed on 7/17/14 @ 3:35 pm</p> <ul style="list-style-type: none"> <li>From this audit 4 med errors were noted. These error for R4- the Metformin was ordered to be held on 7/16/14 and was administered (MD notified and no new received), R5 had multi 2 tabs ordered and 1 tab was transcribed (MD changed to 2 tabs), R6 Facility failed to give Fosamax weekly as ordered for 2 weeks (MD stated to start Fosamax weekly), R7 treatment order of Dry gauze and TAO was ordered 3 times a week and it was transcribed as daily ( MD stated to change to 3 times weekly). None of these residents suffered any ill effects related to these errors.</li> </ul> <p>PROCESSES IMPLEMENTED TO PREVENT</p>	F 309			

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F 309	Continued From page 45 FURTHER OCCURRENCES 1. In-servicing for the nursing staff and nursing assistants was started on 7/16/14 by the Nurse Managers. At this point 84 nursing staff and nursing assistants out of 138 are in-serviced. No member of the nursing staff or nursing assistants will be able to work the floor until they are in serviced. · The facility's Change of Condition Policy and the requirements of MD notification which includes; residents that are experiencing persistent loose stools and have critical potassium levels and other critical/abnormal labs. · The facility's Medication transcription policy which would include the proper transcription of potassium. a. STARTED ON 7/16/14 AND ONGOING AT THIS TIME. 2. The Nurse Managers were in-serviced by the Regional Vice President on 7/17/14 on the following: · The Facility's New Morning Nurses QA Meeting which will include: o Review of the 24 hour condition report to ensure that all residents that have exhibited persistent loose stools have been communicated to the MD and that all new orders have been carried out. o Review of the 24 hour Bowel Record to ensure that any resident that is having continuous diarrhea or 3 loose stools in a 24 hour period has MD notification for proper interventions. o Review of all new orders to ensure that the order was properly transcribed into the Electronic Charting System and that the resident received the treatment promptly. The Nurse responsible for receiving the lab/C-diff culture order will enter into it into the ECS lab tracking. The Nurse Managers will ensure this is completed during	F 309			

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F 309	Continued From page 46 their morning QA review. o Review of the lab tracking sheet to ensure that all C-diff cultures were obtained as ordered. The Nurse responsible for receiving the lab order will enter into it into the ECS lab tracking. o The 2nd shift Supervisor will ensure that all labs/ C-diff cultures obtained are received, distributed to the appropriate responsible nurse, the MD is notified and new orders are transcribed and implemented. o The Morning Nurses QA will review all these completed labs/C-diff cultures the following morning to ensure the 2nd shift Supervisor completed the assigned task. o The Lab Company and all Critical Labs will be called to the DON/designee. The DON/designee will ensure that the MD is notified and ensure that any new orders are carried out. o Properly managing the facility staff to ensure proper resident care is provided.  The Completion date is 7/17/14."  On 7/17/2014 at 8:26 pm, the credible allegation was validated. Staff interviews with licensed nurses and nursing assistants revealed the facility had implemented the following as it related to: 1) actions one should take if a resident is observed or reported with persistent, continued loose stools or diarrhea, 2) changes in stools pattern, 3) physician orders received for stool sample or specimen to be obtained, 4) change in condition policy, 5) physician notification, 6) twenty-four hour condition report and 7) process for entering or transcribing new orders in the electronic charting system for medications and labs.	F 309			
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION	F 318			

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F 318	Continued From page 47  Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  This REQUIREMENT is not met as evidenced by: Based on observations, staff and family interviews and record review, the facility failed to provide range of motion (ROM) services for 2 of 4 resident's with contractures (resident #160 and resident #93) reviewed for range of motion. Findings included:  1. Resident #160 was admitted to the facility on 4/27/12 with cumulative diagnoses of left sided hemiplegia, vascular dementia and seizures. The quarterly Minimum Data Set (MDS) dated 6/7/14 indicated resident #160 had severe cognitive impairment and was coded for impairment in range of motion on one side. There were no restorative or therapy services noted on the MDS. The updated care plan dated 6/14/14 did not include contractures as an identified problem with specific interventions.  In an observation on 7/7/14 at 10:58 AM, resident #160 was lying in bed with his left arm flexed at the elbow lying across his chest. The left hand was in a fist position.  A review of restorative nursing list for residents receiving ROM and splinting, resident #160 did not appear on the list. On 7/9/14 at 12:12 PM, the	F 318	The facility does ensure that a Resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion.  1. Resident#160 was assessed by therapy for contractures needs and ROM program was implemented on 7/22/14. Resident #160 plan of care was updated on 8/11/14. Resident #93 was assessed by therapy for contracture needs and ROM program was implemented on 7/9/14. Resident #93 plan of care was updated on 8/11/14 to reflect the program.  2. Identifying other residents at risk, all other residents were assessed by Therapy to determine their contracture needs. Residents identified with Restorative/therapy needs were identified and a formal program was implemented on 8/8/14. To prevent further occurrences the Nursing Management was in serviced by the Corporate Clinical/Ops on 7/31/14 on the following; The restorative nurse will ensure that each resident in this facility is, screened by Therapy upon admission, change of condition, and at least quarterly for contractures. Restorative Nurse will utilize Therapy referral form to communicate screens for changes of condition, new admissions, and quarterly for contractures. Any Resident needs that are identified are documented, a formal plan is put into place, and directed by the Licensed Therapist, staff is communicated the plan and a care plan is derived.  3. Monitoring will be as followed; the Restorative Nurse will complete the Contracture QA Tool for each new admission and on each resident's quarterly MDS schedule to ensure the resident	8/20/14	



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F 318	<p>Continued From page 48</p> <p>director of nursing stated the MDS nurse was over the restorative program which was responsible for ROM and splinting.</p> <p>In an interview on 7/9/14 at 2:30 PM, resident #160's wife stated he had the contracture to his left hand prior to his admission at the facility. She stated she kept a rolled up wash cloth in his hand when she had him at home and that since his admission to the facility, nobody had discussed the left hand contracture with her. The wife stated she was concerned about his hand getting so fixed that his fingernails would start to cut into his palm. The wife attempted to open resident #160 's left hand but the resident voiced discomfort.</p> <p>In a group interview on 7/9/14 at 3:05 PM the three restorative aides confirmed that resident #160 was not receiving any passive ROM, active ROM or splinting.</p> <p>In an interview on 7/9/14 at 3:22 PM, the rehabilitation director stated resident #160 was screened on admission and again in April 2014. He stated he did not feel splinting services was recommended due to the risk of skin breakdown. He did however recommend ROM services but he neglected to complete a referral form for restorative services. He stated he assumed the floor aides would perform ROM.</p> <p>In an observation on 7/10/14 at 10:30AM, resident #160 was observed in bed with a rolled wash cloth in his left hand. Nursing assistant #4 stated she washed resident #160's hand and put a clean dry wash cloth inside his hand because the nurse told her too. NA #4 stated she was not told anything about ROM and that restorative normally does the ROM on the residents with</p>	F 318	<p>continued</p> <p>has been screened by Therapy, needs are documented, and a formalized plan is implemented as recommended.</p> <p>The QA tools will be reviewed at the morning QA meeting for completeness. If further discrepancies continue to be identified the plan will be revised by the IDT. The Restorative Nurse will be responsible for compliance and all findings will be presented at monthly QA Committee Meetings.</p> <p>5. Compliance date is 8/20/14</p>	8/20/14	

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F 318	<p>Continued From page 49 contractures.</p> <p>In a telephone interview on 7/10/14 at 11:09 AM, the MDS nurse stated the way the restorative program worked was that therapy would refer a resident to her program based on their evaluation and assessment and write out a treatment plan for the restorative aides to follow. The MDS nurse stated she did not receive a referral from therapy based on the screening done in April 2014.</p> <p>In an interview on 7/10/14 at 12:40 PM, the medical director stated he would have expected some sort of ROM services or something to be place in resident #160's hand to prevent further contracture of his left hand.</p> <p>Resident #93 was admitted to the facility on 07/18/2006 with right upper extremity and right lower extremity contractures due to a cerebral vascular accident. As per the Minimum Data Set dated 6/21/14, the resident was determined to be cognitively intact and have range of motion limitations on one side of the body for both upper and lower extremities.</p> <p>The most recent Rehabilitation Screening provided as per documentation was dated for 09/26/13 and was conducted by the Physical Therapy (PT) Rehab Director. The summary stated " History of therapy for upper extremity range of motion and lower extremity range of motion with upper extremity and lower extremity maintenance program established ...(Patient) reports wanting to continue restorative program at</p>	F 318			

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F 318	<p>Continued From page 50</p> <p>this time ...Will follow up with restorative aides to encourage use of previously established equipment and maintenance program. "</p> <p>The care plan dated 06/25/14 identified the potential for further decline due to contractures with the goal as described as " Maintain current range of motion. " No specific approaches were specified on the care plan to address the resident ' s contractures.</p> <p>The care guide corresponding to the resident ' s care plan dated 06/25/14 did not instruct nursing staff to provide any sort of range of motion or splinting services.</p> <p>The resident was observed to be sitting in a wheelchair on 07/07/14 at 11:00 AM. He was contracted at the right elbow and right hand, without any sort of splint in place. He was also observed to be contracted at the right knee, without any sort of splint in place.</p> <p>During an interview with the resident on 07/07/14 at 11:00 AM, he stated that he received range of motion exercises for " a few months in 2009 " but did not know why the services were stopped. He also stated that he used to have leg and arm splints but does not know where they are at the present time and has not used them in years. He mentioned that the leg brace became uncomfortable for him at one point and he was told that he would receive a new brace but he never received it. Resident #93 also stated that the rehab department evaluated him " about 8 months ago " and was told that he was supposed to be referred into the facility ' s restorative program for the contractures but did not know anything more about this referral.</p>	F 318			

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F 318	<p>Continued From page 51</p> <p>Nurse Aide #7 was interviewed on 07/07/14 at 11:30 AM. She stated that Resident #93 currently did not have orders to receive splinting services or any range of motion services by rehab services, restorative nursing services, or conventional nursing services. She stated that she was aware that the resident had multiple contractures and that the resident typically did not let anyone touch his contractures when staff provided routine daily care.</p> <p>The PT Rehab Director was interviewed on 07/09/14 at 3:30 PM. He stated that the resident was last assessed by him on 09/26/13 and that he was aware of Resident #93 ' s multiple contractures. The PT Rehab Director was not able to produce any documentation regarding a referral made to restorative care as specified on the resident ' s Rehabilitation Screening.</p> <p>The PT Rehab Director was again interviewed on 07/10/14 at 10:00 AM. He confirmed that rehab did not pursue getting alternative splints or resuming restorative care for this resident since 09/26/13 as described on the resident ' s Rehabilitation Screening.</p> <p>The facility ' s Restorative Program Director was interviewed on 07/10/14 at 3:30 PM. She confirmed that Resident #93 was never referred to her services by the PT Rehab Director since 09/26/13.</p> <p>The Director of Nursing was interviewed on 07/10/14 at 3:35 PM. She stated that her expectations were that residents with contractures were assessed regularly or even more often then the minimal requirement and that</p>	F 318			

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F 318	Continued From page 52 documented discussions/referrals took place between rehab and restorative care departments. She also stated that her expectations were that all residents received the care that they needed.	F 318			
F 333 SS=J	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on record review, staff, physician and pharmacist consultant interviews, the facility failed to administer potassium as ordered by the physician for a resident with a critical potassium level of 2.3 (3.5 -5.3 reference range) for 1 of 1 residents' records reviewed (Resident #263).  The immediate jeopardy began on 7/8/14 when potassium 20 milliequivalent (meq) was not administered to Resident #263 who had a critical potassium level. The immediate jeopardy was removed on 7/17/14 at 8:47 pm when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity of D (no actual harm with the potential for more than minimal harm) that is not immediate jeopardy to ensure monitoring systems put in place are effective. Findings included:  Resident #263 was admitted into the facility on 4/28/14. Diagnoses included clostridium difficile (C-Diff- a type of infectious diarrhea), diarrhea, hypokalemia (low potassium), hypertension and debility (physical weakness). The admission	F 333	Resident #263 had a C-Diff re-cultured on 7/9/14 during the survey. MD was made aware of loose stools on 7/9/14 during survey. The Potassium errors have been resolved as of 7/14/14 with correct orders. The MD was notified of errors on 7/16/14 and had gave no changes in the current treatment plan. The MD is aware of resident #263 condition and is monitoring closely.  2. A 100% bowel movement audit was completed from 7/10-7/16/14 to identify any residents that are exhibiting persistent diarrhea/ loose stools. The facility printed out the CNA bowel movement charting from the electronic charting system. This audit was completed at 9:03 pm on 7/16/14. This task was completed by Nurse Managers. From this audit 3 residents were identified as having a long history of loose stools. The facility notified MD on 7/16/14 and orders for C-diff cultures were obtained as a precautionary measure. A 100% lab audit was completed for the last 30 days to ensure all labs were obtained and any orders that were received were transcribed and administered as ordered. The Managers printed out all lab orders from the Electronic Charting System to validate the orders. This was completed on 7/16/14 at 9:10 pm. From this audit no further medication errors in relationship to lab results were found. The facility did note that 13 labs were not drawn per orders in the last 30 days. The MD was notified of these errors and new orders were obtained. A 100% in house Resident audit was completed to ascertain if all Changes In Condition were identified by nursing and	7/17/14	

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F 333	<p>Continued From page 53</p> <p>Minimum Data Set completed on 5/9/14 indicated Resident #263 had short and long term memory problems. Decision making was listed as moderately impaired.</p> <p>Lexi-Comp's Geriatric Dosage Handbook, 17th edition in part reads "potassium is the major cation (causes a positive charge) of intracellular (located or occur within the cell) fluid and is essential for conduction of nerve impulses in heart, brain and skeletal muscle; contraction of cardiac, skeletal and smooth muscles; maintenance of normal renal (kidney) function, acid-base balance, carbohydrate metabolism, and gastric (stomach) secretion."</p> <p>A review of the April 2014 admission monthly physician orders revealed Resident #263 was not prescribed potassium on admission into the facility. Medications that related to heart/blood pressure included:</p> <ul style="list-style-type: none"> <li>• Aspirin 325 milligram (mg) by mouth daily</li> <li>• Lisinopril 5 mg by mouth daily</li> </ul> <p>A review of the lab report received by the nursing facility from the lab provider on 5/13/14 revealed a potassium level of 3.6.</p> <p>A review of the medication administration record (MAR) reflected Resident #263 received Lisinopril 5 mg by mouth daily at 9:00 am on 7/1, 7/2, 7/3, 7/4, 7/5 and 7/6/14. The order was indicated as discontinued on 7/6/14. Lisinopril is a medication used to treat conditions such as high blood pressure and congestive heart failure. An action of lisinopril is that it functions to decrease certain chemicals that tighten the blood vessels, thus allowing the blood to flow more smoothly.</p>	F 333	<p>the MD was made aware. This audit was completed from 7/14-7/16/14 by the Nurse Managers.. this was completed on 7/16/14 at 10:37 pm. From this audit there were 19 changes in condition that the facility could not find the MD notification. The MD was notified of all changes on 7/16/14 by the Nurse Managers. Upon notification the MD had no new orders or interventions for these Residents. A 100% MD order audit was completed from 7/10-7/16/14 to ensure that all orders were entered into the Electronic System as ordered. This audit was completed on 7/17/14 at 3:35 pm. From this audit 4 medication errors were noted These errors were for, Metformin was to be held on 7/16/14 and was administered. MD notified and no new order given. Multi tab ordered for 1 tab and 2 were given. MD changed order to 2 tabs. Facility failed to give Fosamax weekly as ordered for 2 weeks. MD changed order to start Fosamax weekly. Treatment order for Dry Gauze and TAO was ordered 3 times a week and it was transcribed as daily. MD changed order to 3 times weekly. None of the Residents suffered any ill effects related to these errors.</p> <p>3. In-servicing for the nursing staff and nursing assistants was started on 7/16/14 by Nurse Managers. In services included, Facility's Change in Condition Policy and the requirements of MD notification which includes; Resident's that are experiencing persistent loose stools and have critical potassium levels and other critical/abnormal labs. The facility's Medication transcription policy was reviewed with nurses to include proper transcription of potassium and other medications. The Nurse</p>	7/17/14	

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F 333	Continued From page 54  A review of a critical lab result, reported to the nursing facility by the lab provider on 7/8/14 at 6:16 am to Nurse #7 in part read "Critical potassium 2.3." Physician #1 was indicated as notified with a new order received on 7/8/14 at 6:18 am by Nurse #7.  A review of a physician telephone order dated 7/8/14 received by Nurse #7 in part read "potassium 20 meq every day."  The MAR did not reflect that potassium 20 meq was administered on 7/8/14 as ordered when the nursing facility was notified of a critical potassium level of 2.3 on 7/8/14 at 6:16 am by the lab provider.  A review of the MAR revealed potassium 20 meq by mouth (15 milliliters) was administered on 7/9/14 at 9:00 am.  A review of the MAR revealed potassium 20 meq tablet was administered by mouth on 7/10/14 at 9:00 am.  A review of the physician order dated 7/10/14; order time not specified, in part read "increase potassium chloride to 20 meq by mouth twice daily." The MAR reflected the resident only received potassium 20 meq once on 7/10/14 at 9:00 am.  A review of the lab report received by the nursing facility from the lab provider on 7/11/14 in part read "potassium 2.2 critical level." The MAR reflected potassium 20 meq was administered once at 9:00 am on 7/11, 7/12 and 7/13/14.	F 333	continued Managers were in serviced by the Regional Vice President on 7/17/14 on the following: the facility's new morning nurses QA meeting to include: review of 24 hour condition report to ensure that all Residents that have exhibited persistent loose stools have been communicated to the MD and new orders have been carried out. Review the 24 hour Bowel Record to ensure that any Resident that is having continuous diarrhea or 3 loose stools in a 24 hour period has MD notification for proper interventions. Review all new orders to ensure that the order was properly transcribed into the Electronic Charting System and that the Resident received the treatment promptly. The Nurse responsible for receiving the lab/C-diff culture order will enter it into the ECS lab tracking. The 2nd shift Supervisor will ensure all labs/C-diff cultures obtained are received, distributed to the appropriate responsible nurse, the MD is notified and new orders are transcribed and implemented. The Morning Nurses QA will review all these completed labs/C-diff cultures the following morning to ensure the 2nd shift Supervisor completed the assigned tasks. The Lab Company and all Critical Labs will be called to the DON/designee. The DONB/designee will ensure that the MD is notified and ensure that any new orders are carried out timely. 4. During the morning nurses QA meeting all areas listed in #2 will be completed by the Nurse Management Team. This new QA meeting was started on 7/17/14 and		

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F 333	<p>Continued From page 55</p> <p>A review of the lab report received by the nursing facility on 7/14/14 at 2:56 pm from the lab provider reported to Nurse #6 in part read "potassium 2.2 critical level."</p> <p>A review of the physician order dated 7/14/14 pm at 3:00 pm read "give potassium 40 meq now, then increase potassium chloride to 40 meq by mouth twice daily for low potassium." The MAR reflected on 7/14/14 potassium 40 meq was administered "pm" and on 7/15/14, potassium 20 meq (2 tablets) was administered at 9:00 am and 5:00 pm.</p> <p>A review of the lab report received by the nursing facility from the lab provider on 7/16/14 in part read "potassium 2.4." The MAR reflected on 7/16/14 potassium 20 meq (2 tablets) was administered at 9:00 am and 4:00 pm.</p> <p>In an interview on 7/10/14 at 5:07 pm, the DON stated she expected all orders to have been obtained as ordered by the physician and the clinical record to reflect such, if the stool sample was unable to be obtained.</p> <p>In an interview on 7/16/14 at 12:54 pm, Nurse #7 acknowledged on 7/8/14 from 7pm-7am she received a critical potassium lab result via telephone from the lab provider; however she was not the primary nurse and thought she conveyed the critical lab (potassium) to Nurse #3. Nurse #7 stated she did not administer potassium 20 meq to the resident on 7/8/14.</p> <p>In an interview on 7/16/14 at 1:28 pm, Nurse #3 who was the primary nurse on 7/8/14 from 7am-7pm indicated she did not administer potassium 20 meq during her shift because she</p>	F 333	<p>Was monitored by the RVP. During this meeting any discrepancies identified will be documented, investigated, and corrected as required. From any discrepancies identified further education or disciplinary action will occur with staff members responsible. If trends are noted this QA process will be revised by the QA Committee. These new QA programs will be a permanent practise of the facility. This QA process will be followed by the QA committee for compliance and revisions if needed. As trends are identified through these QA audits further educational and training will be provided. The facility will contact and set up in servicing on medication errors and transcription with the Pharmacist. The facility will continue to involve the Medical Director in the facility processes in order to seek guidance and support. A member of the Home Office staff will be on site weekly for the next 30 days to offer guidance, support, and training and monitoring of this plan. All findings will be presented to the monthly QA committee meeting.</p> <p>5. Compliance is 7/17/14.</p>	7/17/14	



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F 333	<p>Continued From page 56</p> <p>was not made aware there was an order to administer potassium on 7/8/14.</p> <p>In an interview on 7/16/14 at 1:53 pm, the medical director stated he became aware of the critical potassium level on 7/8/14 "early morning" and ordered for potassium 20 meq to be administered due to the critical lab. He stated he expected the medication to have been administered to the resident on 7/8/14 as ordered, considering the facility staff was aware of the resident critical lab result. He indicated he expected the potassium to have been administered on 7/8/14, because the resident's potassium level was at a critical level and the resident could have had cardiac problems such as an abnormal heart rhythm, while awaiting the potassium to be administered on 7/9/14. He stated on 7/14/14 the resident required more aggressive treatment in which potassium 40 mg was ordered to be given "now" and then to 40 mg twice daily (total of 80 mg daily) because the potassium level continued to drop. As the medical director, he concluded factors which contributed to the low potassium were "fluid loss as a result of continued loose stools/diarrhea."</p> <p>In an interview on 7/16/14 at 4:02 pm, the DON stated per her review of the physician orders, the MAR did not reflect that potassium 20 meq was administered as ordered on 7/8/14. She indicated the MAR reflected potassium 20 meq was not administered until 7/9/14 at 9:00 am. The DON added potassium 20 meq was also ordered to be administered on 7/10, 7/11, 7/12, 7/13/14 twice daily and the MAR reflected the medication was administered once each day at 9:00 am. She stated the order to increase potassium was not transcribed into the electronic computer system</p>	F 333			

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F 333	<p>Continued From page 57</p> <p>properly, so the order was not carried out. The DON concluded her expectation was for the unit manager to have checked the carbon copies of the orders to ensure the physician orders were transcribed properly and carried out.</p> <p>In an interview on 7/17/14 at 12:32 pm, the administrator indicated the facility process for ensuring physician orders were transcribed correctly as ordered revealed when a physician gives an order, the receiving nurse is responsible for ensuring the order is read back for clarity and transcribed into the electronic computer system correctly. She added the unit managers were responsible for following up on new orders daily, to ensure all new orders had been properly transcribed and medications administered as ordered.</p> <p>In an interview on 7/17/14 at 3:09 pm, the facility's consultant pharmacist stated she expected all orders for potassium to have been administered as ordered by the physician due to the resident's critical potassium level.</p> <p>In an interview on 7/17/14 at 6:55 pm, Nurse #7 who worked 7pm-7am when presented the critical lab result dated 7/8/14 acknowledged she 1) was notified by the lab provider on 7/8/14 at 6:16 am as indicated on the lab report, 2) called the medical director as indicated on the lab report on 7/8/14 at 6:18 am, and received an order from the medical director on 7/8/14 at 6:18 am, to "administer potassium 20 meq every day." She stated that she was suppose to transcribe the order into the electronic computer system for the potassium 20 meq to be administered on 7/8/14, however she mistakenly scheduled it to be administered on 7/9/14. Nurse #7 indicated she</p>	F 333			

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F 333	<p>Continued From page 58</p> <p>did not administer the potassium to Resident #263 on 7/8/14 as ordered. Nurse #7 concluded Nurse #3 who worked on 7/8/14 from 7am-7pm took over the care of Resident #263 after her. Nurse #7 indicated she was not sure if she made her (Nurse #3) aware of the critical potassium level/order received.</p> <p>The administrator was notified of the immediate jeopardy on 7/17/14 at 10:10 am. The facility provided the following credible allegation on July 17, 2014 at 8:25 pm for F 333 as follows:</p> <p>"RESIDENT IDENTIFIED At the time this IJ was announced R 263-</p> <ul style="list-style-type: none"> <li>· Had a C-diff re-culture on 7/9/10 During the survey</li> <li>· MD was aware of the loose stools 7/9/10 during the survey</li> <li>· The Potassium errors have been resolved as 7/14/14 with correct orders. The MD was notified of errors on 7/16/14 and had given no changes in the current treatment plan.</li> <li>· The MD is aware of R 263 condition and is monitoring closely.</li> </ul> <p>IDENTIFYING OTHER RESIDENTS AT RISK 1. A 100% Bowel Movement audit was completed from 7/10-7/16/14 to identify any residents that are exhibiting persistent diarrhea/loose stools. The facility printed out the CNA bowel movement charting from the Electronic charting. This audit was completed at 9:03 pm on 7/16/14. This task was completed by the Nurse Managers.</p> <ul style="list-style-type: none"> <li>· From this audit R1, R2 and R3 were identified as having a long history of loose stools. The facility notified the MD of these loose stools on 7/16/14 and orders for C-diff cultures were</li> </ul>	F 333			

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F 333	Continued From page 59 obtained as a safety measure. 2. A 100% lab audit was completed for the last 30 days to ensure all labs were obtained and any orders that were received were transcribed and administered as ordered. The Managers printed out all lab orders from the Electronic Charting system to validate this. This was completed by the nurse managers on 7/16/14 at 9:10 pm. · From this audit no further medication errors in relationship to lab results were observed. The facility did note that 13 labs were not drawn per orders in the last 30 days. The MD was notified of these errors and new orders were obtained. 3. A 100% in house resident audit was completed to ascertain if all changes of Condition 's were identified by nursing and the MD was aware. This audit was completed from 7/14/14-7/16/14 by the Nurse Managers. This was completed on 7/16/14 @ 10:37 PM. · From this audit there were 19 changes of condition that the facility could not find MD notification. The MD was notified of all changes on 7/16/14 by the nurse managers. Upon notification the MD had no new orders or interventions for these residents. 4. A 100% MD order audit was completed from 7/10/14-7/16/14 to ensure that all new orders were entered into the Electronic Charting System as ordered. This process was started on 7/16/14 by the nurse managers. This process will continue and will be completed on 7/16/14 by the nurse managers. This audit was completed on 7/17/14 @ 3:35 pm · From this audit 4 med errors were noted. These error for R4- the Meiformin was ordered to be held on 7/16/14 and was administered (MD notified and no new received), R5 had multi 2 tabs ordered and 1 tab was transcribed (MD changed to 2 tabs), R6 Facility failed to give	F 333			

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F 333	Continued From page 60 Fosamax weekly as ordered for 2 weeks (MD stated to start Fosamax weekly), R7 treatment order of Dry gauze and TAO was ordered 3 times a week and it was transcribed as daily ( MD stated to change to 3 times weekly). None of these residents suffered any ill effects related to these errors.  PROCESSES IMPLEMENTED TO PREVENT FURTHER OCCURRENCES 1. In-servicing for the nursing staff and nursing assistants was started on 7/16/14 by the Nurse Managers. At this point 84 nursing staff and nursing assistants out of 138 are in-serviced. No member of the nursing staff or nursing assistants will be able to work the floor until they are in serviced. · The facility's Change of Condition Policy and the requirements of MD notification which includes; residents that are experiencing persistent loose stools and have critical potassium levels and other critical/abnormal labs. · The facility's Medication transcription policy which would include the proper transcription of potassium. a. STARTED ON 7/16/14 AND ONGOING AT THIS TIME. 2. The Nurse Managers were in-serviced by the Regional Vice President on 7/17/14 on the following: · The Facility's New Morning Nurses QA Meeting which will include: o Review of the 24 hour condition report to ensure that all residents that have exhibited persistent loose stools have been communicated to the MD and that all new orders have been carried out. o Review of the 24 hour Bowel Record to ensure that any resident that is having continuous	F 333			

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F 333	<p>Continued From page 61</p> <p>diarrhea or 3 loose stools in a 24 hour period has MD notification for proper interventions.</p> <ul style="list-style-type: none"> <li>o Review of all new orders to ensure that the order was properly transcribed into the Electronic Charting System and that the resident received the treatment promptly. The Nurse responsible for receiving the lab/C-diff culture order will enter into it into the ECS lab tracking. The Nurse Managers will ensure this is completed during their morning QA review.</li> <li>o Review of the lab tracking sheet to ensure that all C-diff cultures were obtained as ordered. The Nurse responsible for receiving the lab order will enter into it into the ECS lab tracking.</li> <li>o The 2nd shift Supervisor will ensure that all labs/ C-diff cultures obtained are received, distributed to the appropriate responsible nurse, the MD is notified and new orders are transcribed and implemented.</li> <li>o The Morning Nurses QA will review all these completed labs/C-diff cultures the following morning to ensure the 2nd shift Supervisor completed the assigned task.</li> <li>o The Lab Company and all Critical Labs will be called to the DON/designee. The DON/designee will ensure that the MD is notified and ensure that any new orders are carried out.</li> <li>o Properly managing the facility staff to ensure proper resident care is provided.</li> </ul> <p>The Completion date is 7/17/14."</p> <p>On 7/17/2014 at 8:26 pm, the credible allegation was validated. Staff interviews with licensed nurses and nursing assistants revealed the facility had implemented the following as it related to actions one should take if the staff 1) received a physician order for potassium or other meds 2) observed or received report of a resident with</p>	F 333			

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F 333	Continued From page 62 persistent, continued loose stools or diarrhea, 3) changes in stool pattern, 4) physician orders received for stool sample or specimen to be obtained, 5) change in condition policy, 6) physician notification, 7) twenty-four hour condition report and 8) process for entering or transcribing new orders in the electronic charting system for medications and labs.	F 333			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	The facility does have and maintains an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of disease and infection. 1. Resident# 263 had a stool culture completed on 7/9/14. Resident # 263 had an isolation sign posted on 7/9/14. The vital sign equipment in question was sanitized on 7/9/14. 2. Other residents identified at risk during the audit found none as having C-Diff or requiring isolation precautions. 3. Processes to prevent any further occurrences. Nursing staff were in serviced by Infection Control Nurse 7/9/14 and 8/11/14 on the following; the facilities isolation policy, posting of isolation signs, the facilities policy on C-diff, and policy policy on glove use and handwashing. Each department manager has been assigned a Resident care area (Guardian Angel Rounds). Each Manager will conduct daily random room observations During these rounds each Manager will observe for the items listed in #1. Each manager will complete the new quality monitoring tool.(Guardian angel round sheet)	8/20/14	

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F 441	<p>Continued From page 63 hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility 1) failed to post contact isolation notice or signage to alert the residents, staff and visitors to take precautions prior to entering the room; 2) failed to wash hands after leaving the room and before going to the next resident's room; 3) failed to wash hands between care of residents; 4) and failed to disinfect the vital sign equipment for a resident with Clostridium difficile (C-Diff) for 2 of 8 residents reviewed for infection control (Resident #263, #158). Findings included:</p> <p>The facility policy in part read "C-Diff is a spore-forming bacterium that causes diarrhea and more serious intestinal conditions such as colitis, and sepsis. Symptoms of C-Diff disease include watery diarrhea. Precautions: contact precautions while having diarrhea. Special considerations: wash hands with soap and water; do not use an alcohol handrub" The type of contact isolation indicated for C-Diff included "contact isolation." Facility specifications for contact isolation in part read:</p> <p>· "Private room or with a resident who has an active infection with the same organism but with</p>	F 441	<p>continued</p> <p>4. Monitoring will be with QA tools being reviewed daily at the Morning Meeting. Any discrepancies noted will be identified and further interventions will be implemented. The QA process will continue until substantial compliance is obtained from NCDHHS. At that time the QA committee will review and this QA process will continue weekly thereafter. The Infection Control in-servicing will continue at least quarterly. The DON and Administrator will be responsible for compliance and present findings to the monthly QA Committee.</p> <p>5. Facility will be in compliance 8/20/14.</p>		



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F 441	<p>Continued From page 64</p> <p>no other infection (cohorting);</p> <ul style="list-style-type: none"> <li>· Hand hygiene completed prior to donning gloves;</li> <li>· Gloves worn when entering the room and while providing care for the resident;</li> <li>· After glove removal and hand hygiene, hands should not touch potentially contaminated surfaces or items;</li> <li>· Gowns should be donned (put on) prior to entering the room or resident's cubicle and removed before leaving the resident's room;</li> <li>· Dedicated resident care equipment should be considered for the resident, or if use of common equipment or items is unavoidable, the items should be adequately cleaned and/or disinfected before use for another resident." <p>Resident #263 was admitted into the facility on 4/28/14. Diagnoses included C-Diff and diarrhea.</p> <p>A review of the lab report received by the nursing facility on 6/12/14 from the lab provider in part read "clostridium difficile toxin result positive.</p> <p>A review of the physician order date 6/12/14 read "Flagyl 500 milligrams (mg) by mouth three times daily for clostridium difficile for 10 days." The medication administration record (MAR) reflected the last dose of Flagyl was administered on 6/21/14 at 10:00 pm. Flagyl is an antibiotic used to treat bacterial infections</p> <p>A review of the bowel elimination pattern record revealed Resident #263 had loose stools on 6/26, 6/29, 6/30, 7/5, 7/6, 7/7, 7/8, and 7/10/14.</p> <p>A review of the lab report received by the nursing facility on 7/10/14 from the lab provider in part read "clostridium difficile toxin result positive.</p> </li></ul>	F 441			

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F 441	<p>Continued From page 65</p> <p>Critical results called to, read back and verified with unit manager #1 at 8:20 am."</p> <p>Due to the critical lab reported to UM #1 on 7/10/14 at 8:20 am by the lab provider related to positive C-Diff, the physician ordered Vancomycin 125 mg by mouth four times a day for C-Diff for 14 days (Vancomycin is an antibiotic used to treat bacterial infections).</p> <p>During an observation on 7/7/14 at 11:47 am, 2:55 pm, and 4:03 pm, there was no contact isolation signage posted on Resident #263's door. Located on the door were isolation gowns, gloves and masks on a caddy (a storage container with different divisions where item are stored).</p> <p>During an observation on 7/8/14 at 9:45 am, NA (nursing assistant) #6 entered Resident #263's room without any personal protected equipment (PPE) on and obtained vital signs on the resident. At 9:50 am, NA #6 exited the resident's room without washing her hands, proceeded into Resident #158's room and obtained vital signs on the resident. At 9:55 am, NA #6 exited the resident's room, sanitized her hands and then proceeded with the vital sign equipment down the hallway, without cleaning or disinfecting to the 200 hall and left the vital sign equipment (blood pressure cuff and thermometer) midway the hallway for other staff on the hall to use.</p> <p>During a follow-up observation on 7/9/14 at 9:51 am, no contact isolation signage was observed posted on Resident #263's door.</p> <p>In an interview on 7/9/14 at 11:42 am, Nurse #2 and unit manager (UM) #1 stated they were not sure why there was no contact isolation signage</p>	F 441			

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F 441	Continued From page 66 posted on Resident #263's door.  In an interview on 7/9/14 at 12:05 pm Nurse #5 acknowledged that she was the infection control nurse. She stated she was not sure if Resident #263 was supposed to be on contact isolation.  In an interview on 7/9/14 at 12:10 pm, NA #6 stated she was aware Resident #263 was on contact isolation, however she did not know she was suppose to 1) use personal protective equipment when taking vital signs on the resident, 2) wash her hands upon exiting the room, 3) disinfect the vital sign equipment prior to using it on other residents.  In an interview on 7/9/14 at 12:14 pm, the director of nursing stated she expected contact isolation signage to be posted on residents' doors along with the isolation equipment (PPE), employees hands to be washed with soap and water prior to exiting the room, and the PPE to be used per facility policy when caring for residents on contact isolation.	F 441			
F 497 SS=D	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE  The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse	F 497			

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F 497	Continued From page 67 aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure 1 of 1 nursing assistants (NA) acquired 12 hours of in-service training annually (NA #9). Findings included:  NA #9 was hired on 6/20/13. A review of a NA employee list revealed NA #9 had not completed 12 hours of in-service training from 6/21/13 to 7/17/14.  In an interview on 7/17/14 at 12:27 pm, the administrator stated "we do not have record that NAs have acquired 12 hours of in-service training." The administrator stated she expected the training to have been monitored and completed for each NA by the director of nursing (DON). The administrator concluded there was no in-service record to reflect that any of the NAs had received any annual in-service training.  In an interview on 7/17/14 at 12:46 pm, the DON (former ADON) stated at the time she was in the role of the ADON, her duties were multifaceted which included: staff educator, infection control nurse and the unit manager. The DON stated the 12 hour annual requirement had not been met and she could not provide any evidence to reflect otherwise.	F 497	F 497 The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. EMPLOYEE(S) IDENTIFIED 1All CNA's are identified as potentially at risk for this citation. PROCESSES IMPLEMENTED TO PREVENT FURTHER OCCURRENCE: 1.In-Service held 8/6/14 for Human Resources, Nursing, Staff Development and Administration regarding the requirements that must be met for the nursing aides specifically addressing the 12H minimum Education rule as well as the minimal requirement for Evaluations on at least an annual basis. The requirement that In-service education minimally address the needs of the cognitively impaired residents and other topics as deemed appropriate was presented as well. In-services will be conducted regularly for the Nursing Aides which will include documentation of time spent and Topics presented: A.The facility will generate a calendar of In-services to be presented on a regular basis B.The calendar shall be posted in the employee	8/20/14	
F 516 SS=D	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS	F 516			

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F 516	<p>Continued From page 68</p> <p>A facility may not release information that is resident-identifiable to the public.</p> <p>The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>The facility must safeguard clinical record information against loss, destruction, or unauthorized use.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to safeguard 1 of 38 residents' original medical records reviewed to ensure the record was located inside the facility (Resident #167). Findings included:</p> <p>The facility policy for signing out of medical records that was undated in part read "medical records removed from the filing area are to be signed out." The facility policy for retention of medical record in part read "1) medical records shall be retained by the facility in accordance with current applicable laws, 2) medical records of discharge residents will be retained for a period of five years."</p> <p>Resident #167 was admitted into the facility on 1/21/2011 and was a current resident.</p> <p>During an observation on 7/10/14 at 9:30 am, Resident #167's chart was unable to be located for review behind the password locked door on</p>	F 516	<p>continued 497.</p> <p>breakroom and also be available in the staff scheduler's office.</p> <p>C. The calendar shall include in-service education for care of the cognitively impaired</p> <p>D. The calendar shall include a variety of times the in services shall be conducted so it is reasonable for all cna's to receive the required hours.</p> <p>E. Individual learning resources may also be created that would contribute to the educational hours /needs of the cna's.</p> <p>F. The DON or designee will generate a Master list of all cna's and monitor progress and attendance of the cna's.</p> <p>3. the HR department will ensure CNA evaluations are completed annually;</p> <p>A. HR will create and/or ad to the employee file a line listing for the date of the employee evaluation is due.</p> <p>B. Prior to the date due the appropriate manager will be notified of the need of the evaluations to be conducted.</p> <p>C. HR will generate a master list of all cna's regularly to ensure the evaluations are completed timely.</p> <p>D. The completed evaluations will be reviewed with DON and if a plan of action is necessary for specific educational needs it will be addressed at that time.</p> <p>Monitoring:</p> <p>1. this process shall be monitored through the facilities QAPI process.</p> <p>2. The Administrator/designee will meet with HR personnel and the DON/Staff development designee weekly for 4 weeks to assess progress made.</p> <p>3. Upon completion of the 4 weekly QA process,</p>		

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F 516	<p>Continued From page 69 the 300 hallway.</p> <p>Nurse #9 was interviewed on 7/10/14 at 9:45 am. She was asked to locate the original record. She responded that she would search for it. Upon going into the chart room on the hallway where Resident #167 resided, Nurse #9, indicated that she did not see where the chart had been signed out. She added that she would continue to search for the chart. At 10:50 am, Nurse #9 reported that the chart was not located.</p> <p>In an interview on 7/10/14 at 11:00 am, the medical record coordinator (MRC) stated a search had begun throughout the facility for the medical record (hard copy chart), however the record was not located and they were not sure where the record was located, or if the record was still inside of the building. A newly developed hard copy medical record was provided by the MRC and it included the following resident identifying information: face sheet with demographic information, allergies, diagnoses, psychiatric consult, physician orders, labs, and an elopement risk assessment.</p> <p>On 7/10/14 at 3:55 pm, the MRC was interviewed in the presence of the administrator. The MRC confirmed the original medical record was not inside the building. The MRC indicated the following information was contained in the record, "discharge summary, face sheet, physician progress notes, psychiatric consult, physician orders and labs." She indicated to date the facility did not know how long the original medical record had been missing. The MRC stated the record should have been located behind the password locked door on the hallway, where Resident #167 resided. The MRC concluded the process for</p>	F 516	<p>continued 497</p> <p>will be reviewed at the regular monthly QAPI.</p> <p>1. Resident #167 the medical record chart was not found. It was recreated by Medical Records</p> <p>2. All Residents were at risk. A 100% chart audit was performed for the entire facility on 7/10/14 and no other charts were missing or not easily accessed.</p> <p>3. Managers were in-serviced on 8/6/14 by Corporate Risk Manager and Staff in-serviced on 8/11/14 regarding Facility must safeguard clinical record information against loss, destruction, and or unauthorized use. The HIM policy and procedure-Physical Security of Manual/Paper records; maintaining a Record sign out system. HIM-Record Sign out Log.</p> <p>4. Medical Records Coordinator and Ward Clerk will review daily the sign out log to ensure proper procedure is maintained to ensure safeguarding of paper/electronic resident records. Medical records Coordinator will report to Daily QA Committee x 4 weeks and then monthly. Findings will be presented monthly to the QA Committee.</p> <p>5. Substantial compliance will be 8/20/14.</p>	8/20/14	

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F 516	Continued From page 70 tracking resident charts was the staff signed the chart out; however, she did not see where the chart had been signed out.  In an interview on 7/10/14 at 4:06 pm the administrator stated she expected the medical record to have been maintained by the facility and knowledge of where the chart was located in the facility.	F 516			