STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING ______ B. WING ______	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CHARLOTTE	**4801 RANDOLPH RD CHARLOTTE, NC 28211**

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F 000	INITIAL COMMENTS 483.10 (F157) at J Immediate jeopardy began on 03/10/14 when Resident #1 had a decrease in stools through her colostomy and began having formed stools rectally. Immediate jeopardy was removed on 03/21/14 at 1:15 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. 483.25 (F309) at J Immediate jeopardy began on 03/10/14 when Resident #1 had a decrease in stools through her colostomy and was having an increase in formed stools rectally. Immediate jeopardy was removed on 03/21/14 at 1:15 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.	F 000		
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	F 157		3/22/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 04/11/2014

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

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F 157	Continued From page 1 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 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. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record reviews and physician and staff interviews the facility failed to notify the physician and responsible party of continued changes in condition and vital signs for 1 of 4 sampled residents with a change in condition. (Resident #1). Immediate jeopardy began on 03/10/14 when Resident #1 had a decrease in stools through her colostomy and began having formed stools rectally. Immediate jeopardy was removed on 03/21/14 at 1:15 PM when the facility provided	F 157	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907_____ F157 Deficiency Corrected 1. Corrective action has been	

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F 157	Continued From page 2 and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. The findings included: Resident #1 was admitted to the facility on 02/28/14 with diagnoses which included a stage 4 pressure ulcer, difficulty swallowing, muscle weakness, chronic lung disease, a history of sepsis, polymyositis (chronic inflammation of muscles) and a stroke. A review of a hospital discharge summary dated 02/28/14 indicated Resident #1 had a sacral wound infection and was taken to the operating room on 01/03/14 for wound debridement and had a diverting colostomy performed to avoid stool contamination of the sacral wound. The notes further indicated Resident #1 had a percutaneous endoscopic gastrostomy tube (PEG) placed for tube feedings due to poor oral intake. A review of the admission Minimum Data Set (MDS) dated 03/07/14 indicated Resident #1 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS also indicated Resident #1 required extensive assistance for activities of daily living, was totally dependent on staff for bathing and had an indwelling urinary catheter, colostomy due to stage 4 pressure ulcer and tube feedings for nutrition and wound healing.	F 157	accomplished for the alleged deficient practice in regards to Resident #1. Licensed nurse notified Physician and responsible party on 3/12/14 regarding resident #1 condition. Physician order received to transfer to hospital for evaluation of stool seepage pending coordination of services through Carolina Specialty Hospital. Responsible party was notified and resident #1 was transferred on 3/12/14. 2. Current residents have the potential to be affected by the alleged deficient practice to notify physician or nurse practitioner regarding change of condition or clarification of orders. Director of nursing in-serviced staff involved in alleged deficient practice one on one. Staff was in-serviced to clarify immediacy for any orders regarding transfers to a specialized acute care hospital for wound care intervention. Director of Nursing and/or Unit Managers reviewed charts of the facility on March 19, 2014, with a look back from February 7, 2014 (date of compliance for last recertification survey) through March 19, 2014. There were no residents identified with changes in condition during the review. The Director of Nursing and/or Unit Managers and Supervisors along with nursing staff made clinical rounds on all current residents utilizing the facility established process of Stop and Watch and chart reviews were conducted along with the clinical rounds and no residents with change of conditions were identified. 3. Measures put into place to ensure	

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F 157	Continued From page 3 A review of the admission nurse's note dated 02/28/14 indicated Stage 4 pressure ulcer on sacrum: 24.4 centimeters (cm) length; 15 cm width; 4.7 cm depth. A review of a nurse's note dated 03/10/14 at 4:39 AM indicated colostomy with liquid brown stool and also passes stool by rectum at times. A review of a Nurse Practitioner (NP) progress note dated 03/11/14 with no time indicated revealed she was asked to see Resident #1 to evaluate "diarrhea" with multiple medical problems including Stage 4 sacral wound as well as recent diverting colostomy. The notes further indicated staff reported stool from rectum draining into wound and requested a rectal tube. The notes indicated Resident #1's vital signs were blood pressure 108/80; temperature 98.9 Fahrenheit (F); Pulse 101, respirations 20; abdomen tender and protrudes throughout; sacral dressing positive for stool in dressing. The notes indicated an assessment of increased leaking stool rectum that was excessive and questionable fistula (an abnormal passage between 2 hollow or tubular organs); decreased oral intake and tachycardia (rapid heart rate) with suspected dehydration and abdominal pain with questionable sepsis. The notes further indicated to send back to a specialty hospital for evaluation of stool leakage from rectum with questionable fistula and evaluate for dehydration. A review of an order by a NP dated 03/11/14 with no time indicated revealed back to specialty hospital. Evaluate excessive stool rectum ? fistula, tachycardia - ? dehydration/sepsis.	F 157	that the alleged deficient practice does not recur includes: Medical Director educated the Nurse Practitioner on 3/19/14, when patient has acute change of condition that could potentially require hospitalization to refer to the nearest hospital for evaluation. Director of Nursing and/or Unit Managers began reeducating nursing supervisors and licensed nursing staff on 3/19/14, regarding notification of physician and responsible party for change of condition and follow through of physician orders. No staff will be allowed to work until receiving In-service. Director of Nursing and/or Unit Supervisors began reeducating licensed nurses on March 19, 2014 regarding the facility adopted processes for SBAR (process of assessment and notification of change of condition) and Stop and Watch Program (process in which any nurse can identify a change of condition in a resident). All nurses were instructed to contact facility physician or on call physician for further clarifications. Changes of condition identified through Stop and Watch will be channeled through established systems of care such as the 24 hour report and chart reviews during morning meeting. Changes in condition will be referred to the Physician or extender for review and intervention in a timely manner. Nursing Staff will not be permitted to work until in-services received. Completion Date March 21, 2014. In-service will be provided for all new licensed staff during orientation. We will continue to notify families and Physician promptly with changes in condition.	

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F 157	Continued From page 4 A review of a nurse's note dated 03/11/14 at 7:25 PM indicated the NP was advised Resident #1 continued to have stool leakage from the rectum and the NP noted Resident #1 had a rapid heart rate and pulse was 135. The notes further indicated the NP wrote an order for Resident #1 to return to specialty hospital for evaluation of excessive stool from rectum - possible fistula; rapid heart rate due to possible dehydration or sepsis. The notes revealed a copy of the NP's order was left for the next morning's supervisor to follow through for Resident #1 to return to the specialty hospital. A review of a nurse's note dated 03/11/14 indicated at 8:00 PM Resident #1's oxygen saturation was checked and was between 88 percent and 91 percent and she was placed on oxygen at 2 liters per minute by nasal cannula. A review of a nurse's note dated 03/11/14 at 8:50 PM indicated blood pressure medication was not given due to decreased blood pressure of 101/80. A review of a nurse's note dated 03/11/14 at 10:00 PM indicated Resident #1's oxygen saturation percentage was 97 and Resident #1 was placed on "stop and watch" due to continued rapid heart rate of 130-135 and increased temperature from 98.9 degrees F at first of shift to 99.6 degrees F at 10:00 PM. The notes indicated will report to on-coming shift. A review of a facility document titled Stop and Watch Early Warning Tool dated 03/11/14 at 11:00 PM indicated Resident #1 seemed different than usual, was more confused, had a change in skin color or condition with rapid heart rate of 130-135, increased temperature 98.9 degrees F -	F 157	Director of Nursing and/or Unit Managers will review all physician orders in daily operation/clinical meeting beginning March 20, 2014, for follow through of order and notification of responsible party. The Director of Nursing and/or Unit Managers will review all orders in daily operation/clinical meeting beginning March 20, 2014, which includes residents with change of condition as determined by licensed staff, to assure Physician and responsible party notification. Any negative findings found by Licensed Nurses will be reported to Physician in timely manner. 4. Director of Nursing and/or Unit Mangers will analyze audits for patterns/trends and report in Quality Assurance weekly for 4 weeks and then monthly for 3 months to evaluate the effectiveness of the above plan and will adjust the plan based on outcomes/trends identified.	

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99.6 degrees F and decreased oxygen saturation 88-91 percent.

A review of a handwritten note on the Stop and Watch Early Warning Tool dated 03/12/14 at 12:00 AM indicated temperature was 99.4 degrees F and oxygen saturation was 96 percent on oxygen.

A review of a handwritten note on the Stop and Watch Early Warning Tool dated 03/12/14 at 3:00 AM indicated temperature was 100.6 degrees F, oxygen saturation 95 percent, blood pressure 86/52, respirations 22 and pulse 134-144 and irregular.

A review of a nurse's note dated 03/12/14 at 3:58 AM indicated stop and watch continued from previous shift and Resident #1 continued to have a rapid heart rate, low grade temperature and oxygen saturation was 95 percent on 2 liters of oxygen. The notes also indicated Resident #1 yelled out when touched or repositioned.

A review of a nurse's note dated 03/12/14 at 8:15 AM indicated Resident #1 was alert but confused. The notes revealed during shift report the 11:00 PM to 7:00 AM nurse reported resident had been placed on stop and watch due to a change in her condition. The notes indicated a call was made to the specialty hospital and was informed facility did not usually take residents back after they had been discharged from the facility. The notes indicated Resident #1's blood pressure was 95/59, temperature 101.1 degrees F, Pulse 134, respirations 22 and was transported to hospital emergency room by emergency medical services.

A review of an emergency room history and

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physical dated 03/12/14 at 8:36 AM indicated Resident #1 presented to the emergency room with fever, decreased mental status, rapid heart rate and low blood pressure. She was admitted to the intensive care unit for management of septic shock (a serious condition that occurs when an overwhelming infection leads to life-threatening low blood pressure) and acute respiratory failure that required mechanical ventilation with a ventilator.

During an interview on 03/18/14 at 3:45 PM Nurse #1 stated she worked on the 3:00 PM to 11:00 PM shift and was assigned to care for Resident #1. She explained Resident #1 had a very large wound on her buttocks and had a colostomy, urinary catheter and a feeding tube. She explained the leaking of stool from Resident #1's rectum was getting worse and she was concerned that stool was getting in the sacral wound. She explained the NP was in the facility making her weekly rounds on 03/11/14 between 5:00 and 6:00 PM and saw Resident #1 and wrote an order for Resident #1 to go back to a specialty hospital to have her colostomy checked. She stated she thought the NP wanted to send her back to the specialty hospital so she could see the surgeon who did her colostomy and did not question the NP about the order. Nurse #1 confirmed Resident #1's heart rate and temperature had gone up and she had put her on oxygen because her oxygen saturation percentages were low and she reported to the night shift nurse to keep a close eye on Resident #1. She verified she did not call the physician on call or the responsible party during her shift on 03/11/14 to report changes in Resident #1's condition because she did not think the changes were significant enough to call them.

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F 157	Continued From page 7 During an interview on 03/18/14 at 4:11 PM the NP stated when she came to the facility on 03/11/14 to make her rounds between 5:00 and 6:00 PM nursing staff had left her a note and wanted her to order a rectal tube for Resident #1 because she was leaking stool from her rectum. She explained she went to assess Resident #1 and she was very lethargic, her belly was really tender and distended and her pulse was increased. She stated she could not get any history from Resident #1 so she looked at her laboratory results and medical record, and determined she was anemic, was not eating and had stool coming out of her colostomy and her rectum which was the wrong place. She stated when she wrote the order to send Resident #1 to the specialty hospital she meant for Resident #1 to be sent out to the hospital right then, like right away. She further stated if staff met an obstruction to send her to the specialty hospital they should have called her back since she was in the facility for another 45 minutes to an hour after she saw Resident #1 or they should have called the on-call physician to get clarification or orders to send her to any emergency room The NP confirmed Resident #1 had a definite change in her vital signs on 03/11/14 and she remembered she specifically told Nurse #1 to send her out because she was not waiting to get labs because Resident #1 was metabolically unstable and was too sick to be there. She stated she was not aware Resident #1 was not sent out of the facility to a hospital until the next day. During a follow up interview on 03/18/14 at 4:25 PM Nurse #1 confirmed she remembered the NP said Resident #1 needed be sent out. She stated	F 157		

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F 157	Continued From page 8 when she saw the NP's order she thought the NP wanted Resident #1 to return to the specialty hospital to see the surgeon who did her previous surgery so she took the order to a 3:00 PM -11:00 PM supervisor and talked with her about it. She explained the supervisor told her the specialty hospital was not a regular hospital and did not have an emergency room and they would have to make an appointment the next day for for her to go there. She stated she did not call the NP back for clarification after she talked with her supervisor. During an interview on 03/18/14 at 4:38 PM the 3:00 PM to 11:00 PM Nursing Supervisor confirmed she was told by Nurse #1 that Resident #1 had a high pulse but did not remember anything about an elevated temperature or low oxygen saturation percentages. She stated she and Nurse #1 did not discuss sending Resident #1 to the hospital that night and she did not see Resident #1 during the 3:00 PM to 11:00 PM shift on 03/11/14 because there was no reason to see Resident #1 based on what she had been told. She further stated she did not call the physician on call or Resident #1's responsible party on 03/11/14. During an interview on 03/19/14 at 6:48 AM Nurse #2 explained Nurse #3 who was Resident #1's assigned nurse on the 11:00 PM to 7:00 AM shift told her Resident #1 was supposed to be sent to a specialty hospital in the morning but she knew the specialty hospital did not have an emergency room and they would not take a resident back unless it was arranged in advance and it could take all day for them to accept or reject admission of the resident. She stated since she was not assigned to Resident #1's care	F 157		

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F 157	Continued From page 9 she did not question Nurse #3 about it. During an interview on 03/19/14 at 8:45 AM Nurse #4 explained she was the day shift nurse assigned to Resident #1 on 03/12/14 and got a shift report from Nurse #3 between 6:45 AM and 7:00 AM. She stated she was told Resident #1 was seen by the NP on the 3:00 PM - 11:00 PM shift and wanted Resident #1 to go back to the specialty hospital but explained to Nurse #3 she had concerns about sending Resident #1 to the specialty hospital because she didn't think they took residents back after they had been discharged from there. Nurse #4 explained she picked up the phone and called the specialty hospital and spoke with a nurse because the admissions department was not open and the nurse told her it would be unusual for them to accept Resident #1 back to their facility and she would have to talk to her supervisor. Nurse #3 further stated she did not feel comfortable waiting for the specialty hospital to call her back because she had concerns about Resident #1's rapid heart rate, fever, dehydration, and possible sepsis. She stated she called her supervisor who was also the Assistant Director of Nursing (ADON) and reported her concerns about Resident #1's condition and then sent Resident #1 to the hospital. During an interview on 03/19/14 at 10:12 AM Nurse #3 verified she was the night shift nurse who was assigned to care for Resident #1 from 11:00 PM on 03/11/14 - 7:00 AM shift on 03/12/14. She explained Nurse #1 told her in the shift report that the NP had seen Resident on 03/11/14 and she had initiated a stop and watch form because she had a rapid heart rate and her oxygen saturation percentages were low and she	F 157		

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F 157	Continued From page 10 had started oxygen. She stated Nurse #1 told her the NP told her Resident #1 needed to go back to the specialty hospital to see her doctors who had seen her before and the second shift supervisor had printed off the NP order and had written a note for the day shift nurse to get the resident admitted in the morning. She verified she did not call the physician on call since the NP had already assessed her and she did not want to overstep the doctor's orders that had been written to send her to the specialty hospital. She also stated she did not call Resident #1's responsible party during her shift to report changes in condition. During an interview on 03/19/14 at 10:58 AM the ADON verified she was not called during the evening shift on 03/11/14 or during the night shift on 03/12/14. She stated the first call she received was a telephone call as she was driving to work from Nurse #3. She stated Nurse #3 told her about the Resident #1's condition and the NP order to send Resident #1 to the specialty hospital. She stated she instructed her to call the physician and when she arrived at the facility emergency medical services was there to transport Resident #1 to the hospital. During a phone interview on 03/21/14 at 9:14 AM with Resident #1's responsible party she confirmed staff did not call her on 03/11/14 or during the night of 03/12/14 before Resident #1 was sent to the hospital. She stated she expected nursing staff to call her and let her know if they saw something different. She stated if they had called her on 03/11/14 she would have told them to send Resident #1 to the emergency room at the hospital.	F 157		

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During an interview on 03/21/14 at 9:48 AM the Director of Nursing stated she was not called during the evening of 03/11/14 or during the night of 03/12/14 regarding changes in Resident #1's condition. She further stated it was her expectation that nursing staff should notify a resident's physician and responsible party any time a resident had a change in condition.

The facility's Administrator and Director of Nursing were notified of Immediate Jeopardy on 03/19/14 at 2:33 PM for Resident #1. The facility provided a credible allegation of compliance on 03/21/14 at 1:15 PM. The following interventions were put into place by the facility to remove the Immediate Jeopardy.

Credible Allegation of Compliance for Notification of Physician and Responsible Party

Identified Incident of Immediate Jeopardy Identified
F157 Notification of Physician

Resident(s) Identified
Director of nursing in-serviced staff involved in alleged deficient practice one on one. Staff was in-serviced to clarify any orders regarding transfer to hospital. All licensed staff was in-serviced regarding clarification of transfer orders. Resident remains in hospital.

Other Residents with Potential to be affected by the Immediate Jeopardy Incident

· Current residents have the potential to be affected by the alleged deficient practice to notify physician or nurse practitioner regarding change of condition or clarification of orders.

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F 157	Continued From page 12 · Director of Nursing and/or Unit Managers reviewed charts of the facility on March 19, 2014, with a look back from February 7, 2014 (date of compliance for last recertification survey) through March 19, 2014. There were no residents identified with changes in condition during the review. The Director of Nursing and/or Unit Managers and Supervisors along with nursing staff made clinical rounds on all current residents utilizing stop and watch tool and chart reviews were conducted along with the clinical rounds and no residents with change of conditions were identified. Notification of the Allegation of Immediate Jeopardy and actions taken: · Medical Director will educate the Nurse Practitioner on 3/19/14, when patient has acute change of condition that could potentially require hospitalization to refer to the nearest hospital for evaluation. Director of Nursing and/or Unit Managers will begin educating nursing supervisors and licensed nursing staff on 3/19/14, regarding notification of physician and responsible party for change of condition and follow through of physician orders. No staff will be allowed to work until receiving In-service. Director of Nursing and/or Unit Supervisors began educating licensed nurses' on March 19, 2014 regarding use of SBAR (process of assessment and notification of change of condition) and Stop and Watch Program (process in which any nurse can identify a change of condition in a resident). All nurses were instructed to contact facility physician or on call physician for further clarifications. Any change of condition identified through Stop and Watch is documented on 24 hour report and the chart for review during morning meeting. Any change of	F 157		

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F 157	Continued From page 13 condition will be immediately referred to Physician for review and physician orders are followed in a timely manner. Nursing Staff will not be permitted to work until in-services received. Completion Date March 21, 2014. In-service will be provided for all new licensed staff during orientation. We will continue to notify families and Physician promptly with changes in condition. Immediate Changes to Facility Systems: · Director of Nursing and/or Unit Managers will review all physician orders in daily operation/clinical meeting beginning March 20, 2014, for follow through of order and notification of responsible party. The Director of Nursing and/or Unit Managers will review all orders in daily operation/clinical meeting beginning March 20, 2014, which includes residents with change of condition as determined by licensed staff, to assure Physician and responsible party notification. Any negative findings found by Licensed Nurses will be reported to Physician in timely manner. Immediate jeopardy was removed on 03/21/14 at 1:15 PM when interviews with nursing staff revealed awareness of expectations to notify the physician and responsible party when a resident had a change in condition. They further explained they were expected to communicate at the change of shift any changes in a resident's condition, document the changes on the new Situation, Assessment, Background and Request (SBAR) forms and Stop and Watch Early Warning Tools, the 24 hour reports and document notification to the physician and responsible party.	F 157		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		3/22/14

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F 309 SS=J	Continued From page 14 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record reviews and physician and staff interviews, the facility failed to identify and assess the need for medical intervention for a resident with a colostomy who had had an increase in stools rectally and had changes in vital signs in 1 of 4 sampled residents with a change in condition. (Resident #1). Immediate jeopardy began on 03/10/14 when Resident #1 had a decrease in stools through her colostomy and was having an increase in formed stools rectally. Immediate jeopardy was removed on 03/21/14 at 1:15 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. The findings included: Resident #1 was admitted to the facility on 02/28/14 with diagnoses which included a stage 4 pressure ulcer, difficulty swallowing, muscle	F 309	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907_____ F309 Deficiency Corrected 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #1. Licensed nurse notified Physician and responsible party on 3/12/14 regarding resident #1 condition. Physician order received to transfer to hospital for evaluation of stool seepage pending coordination of services through Carolina Specialty hospital. Responsible party notified and resident #1 was transferred hospital on 3/12/14. 2. Current residents have potential to be affected by the alleged deficient practice	

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F 309	Continued From page 15 weakness, chronic lung disease, a history of sepsis, polymyositis (chronic inflammation of muscles) and a stroke. A review of a hospital discharge summary dated 02/28/14 indicated Resident #1 had a sacral wound infection and was taken to the operating room on 01/03/14 for wound debridement and had a diverting colostomy performed to avoid stool contamination of the sacral wound. The notes further indicated Resident #1 had a percutaneous endoscopic gastrostomy tube (PEG) placed for tube feedings due to poor oral intake. A review of the admission Minimum Data Set (MDS) dated 03/07/14 indicated Resident #1 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS also indicated Resident #1 required extensive assistance for activities of daily living, was totally dependent on staff for bathing and had an indwelling urinary catheter, colostomy due to stage 4 pressure ulcer and tube feedings for nutrition and wound healing. A review of the admission nurse's note dated 02/28/14 indicated a Stage 4 pressure ulcer on sacrum: 24.4 centimeters (cm) length; 15 cm width; 4.7 cm depth. A review of a nurse's note dated 03/10/14 at 4:39 AM indicated colostomy with liquid brown stool and also passes stool by rectum at times. A review of a Nurse Practitioner (NP) progress note dated 03/11/14 with no time indicated revealed she was asked to see Resident #1 to	F 309	to maintain well being of resident. Director of nursing in-serviced staff involved in alleged deficient practice one on one. Staff was in-serviced to clarify immediacy for any orders regarding transfers to a specialized acute care hospital for wound care intervention. Director of Nursing and/or Unit Managers reviewed charts of the facility on March 19, 2014, with a look back from February 7, 2014 (date of compliance for last recertification survey) through March 19, 2014. There were no residents identified with changes in condition during the review. The Director of Nursing and/or Unit Managers and Supervisors along with nursing staff made clinical rounds on all current residents utilizing the facility established process of Stop and Watch and chart reviews were conducted along with the clinical rounds and no residents with change of conditions were identified. 3. Measures put into place to ensure that the alleged deficient practice does not recur includes: Medical Director educated the Nurse Practitioner on 3/19/14, when patient has acute change of condition that could potentially require hospitalization to refer to the nearest hospital for evaluation. Director of Nursing and/or Unit Managers will begin reeducating nursing supervisors and licensed nursing staff on 3/19/14, regarding notification of physician and responsible party for change of condition and follow through of physician orders. No staff will be allowed to work until receiving In-service. Director of Nursing and/or Unit Supervisors began reeducating licensed nurses on March	

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F 309	Continued From page 16 evaluate "diarrhea" with multiple medical problems including Stage 4 sacral wound as well as recent diverting colostomy. The notes further indicated staff reported stool from rectum draining into wound and requested a rectal tube. The notes indicated Resident #1's vital signs were blood pressure 108/80; temperature 98.9 Fahrenheit (F); Pulse 101, respirations 20; abdomen tender and protrudes throughout; sacral dressing positive for stool in dressing. The notes indicated an assessment of increased leaking stool from rectum that was excessive and questionable fistula (an abnormal passage between 2 hollow or tubular organs); decreased oral intake and tachycardia (rapid heart rate) with suspected dehydration and abdominal pain with questionable sepsis. The notes further indicated to send back to a specialty hospital for evaluation of stool leakage from rectum with questionable fistula and evaluate for dehydration. A review of an order by a NP dated 03/11/14 with no time indicated revealed back to specialty hospital. Evaluate excessive stool rectum? fistula, tachycardia - ? dehydration/sepsis. A review of a nurse's note dated 03/11/14 at 7:25 PM indicated the NP was advised Resident #1 continued to have stool from the rectum and the NP noted Resident #1 had a rapid heart rate and pulse was 135. The notes further indicated the NP wrote an order for Resident #1 to return to specialty hospital for evaluation of excessive stool from rectum - possible fistula; rapid heart rate due to possible dehydration or sepsis. The notes revealed a copy of the NP's order was left for the next morning's supervisor to follow through for Resident #1 to return to the specialty hospital.	F 309	19, 2014 regarding the facility adopted processes for SBAR (process of assessment and notification of change of condition) and Stop and Watch Program (process in which any nurse can identify a change of condition in a resident). All nurses were instructed to contact facility physician or on call physician for further clarifications. Changes of condition as identified through Stop and Watch will be channeled through established systems of care such as the 24 hour report and the chart for review during morning meeting. Changes in condition will be referred to the Physician or extender for review and intervention in a timely manner. Nursing Staff will not be permitted to work until in-services received. Completion Date March 21, 2014. In-service will be provided for all new licensed staff during orientation. We will continue to notify families and Physician promptly with changes in condition. Director of Nursing and/or Unit Managers will review all physician orders in daily operation/clinical meeting beginning March 20, 2014, for follow through of order and notification of responsible party. The Director of Nursing and/or Unit Managers will review all orders in daily operation/clinical meeting beginning March 20, 2014, which includes residents with change of condition as determined by licensed staff, to assure Physician and responsible party notification. Any negative findings found by Licensed Nurses will be reported to Physician in timely manner. 4. Director of Nursing and/or Unit	

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F 309	Continued From page 17 A review of a nurse's note dated 03/11/14 indicated at 8:00 PM Resident #1's oxygen saturation was checked and was between 88 percent and 91 percent and she was placed on oxygen at 2 liters per minute by nasal cannula. A review of a nurse's note dated 03/11/14 at 8:50 PM indicated blood pressure medication was not given due to decreased blood pressure of 101/80. A review of a nurse's note dated 03/11/14 at 10:00 PM indicated Resident #1's oxygen saturation percentage was 97 and Resident #1 was placed on "stop and watch" due to continued rapid heart rate of 130-135 and increased temperature from 98.9 degrees F at first of shift to 99.6 degrees F at 10:00 PM. The notes indicated will report to on-coming shift. A review of a facility document titled Stop and Watch Early Warning Tool dated 03/11/14 at 11:00 PM indicated Resident #1 seemed different than usual, was more confused, had a change in skin color or condition with rapid heart rate of 130-135, increased temperature 98.9 degrees F - 99.6 degrees F and decreased oxygen saturation 88-91 percent. A review of a handwritten note on the Stop and Watch Early Warning Tool dated 03/12/14 at 12:00 AM indicated Resident #1's temperature was 99.4 degrees F and oxygen saturation was 96 percent on oxygen. A review of a handwritten note on the Stop and Watch Early Warning Tool dated 03/12/14 at 3:00 AM indicated Resident #1's temperature was 100.6 degrees F, oxygen saturation 95 percent, blood pressure 86/52, respirations 22 and pulse	F 309	Managers will analyze audits for patterns/trends and report in Quality Assurance weekly for 4 weeks and then monthly for 3 months to evaluate the effectiveness of the above plan and will adjust the plan based on outcomes/trends identified.	

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134-144 irregular.

A review of a nurse's note dated 03/12/14 at 3:58 AM indicated stop and watch continued from previous shift and Resident #1 continued to have a rapid heart rate, low grade temperature and oxygen saturation was 95 percent on 2 liters of oxygen. The notes also indicated Resident #1 yelled out when touched or repositioned.

A review of a nurse's note dated 03/12/14 at 8:15 AM indicated Resident #1 was alert but confused. The notes revealed during shift report the 11:00 PM to 7:00 AM nurse reported resident had been placed on stop and watch due to a change in her condition. The notes indicated a call was made to the specialty hospital and was informed since resident had been there previously they usually did not take residents back once they had been discharged. The notes indicated Resident #1's blood pressure was 95/59, temperature 101.1 degrees F, Pulse 134, respirations 22 and she was transported to hospital emergency room by emergency medical services.

A review of an emergency room history and physical dated 03/12/14 at 8:36 AM indicated Resident #1 presented to the emergency room with fever, decreased mental status, rapid heart rate and low blood pressure. She was admitted to the intensive care unit for management of septic shock (a serious condition that occurs when an overwhelming infection leads to life-threatening low blood pressure) and acute respiratory failure that required mechanical ventilation with a ventilator.

During an interview on 03/18/14 at 3:45 PM Nurse #1 stated she worked on the 3:00 PM to

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F 309	Continued From page 19 11:00 PM shift and was assigned to care for Resident #1. She explained Resident #1 had a very large wound on her buttocks and had a colostomy, urinary catheter and a feeding tube. She explained the leaking of stool from Resident #1's rectum was getting worse and she was concerned that stool was getting in the wound on her buttocks. She explained the NP was in the facility making her weekly rounds on 03/11/14 between 5:00 and 6:00 PM and saw Resident #1 and wrote an order for Resident #1 to go back to the hospital to have her colostomy checked. She stated she thought the NP wanted to send her back to the specialty hospital so she could see the surgeon who did her colostomy. Nurse #1 confirmed she initiated the Stop and Watch Early Warning Tool as part of her report to the night shift nurse on 03/11/14 because Resident #1's heart rate and temperature had gone up and she had put her on oxygen because her oxygen saturation percentages were low. She explained the stop and watch was a tool to document changes in a resident's condition and for reporting to the on-coming shift. She verified she did not call the NP or physician on call during her shift but she reported to the night shift nurse to keep a close eye on Resident #1 since her temperature had gone up to 99.6 and her oxygen saturation percentages were low and she had started oxygen. During an interview on 03/18/14 at 4:11 PM the NP stated she came to the facility on 03/11/14 between 5:00 and 6:00 PM to make her usual weekly rounds and nursing staff had left her a note and wanted her to order a rectal tube for Resident #1 because she was having stools from her rectum. She explained she went to assess Resident #1 and she was very lethargic and out	F 309		

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of it, her belly was really tender and distended and her pulse was increased. She stated she could not get any history from Resident #1 so she looked at her laboratory results and medical record, and determined she was anemic, was not eating, and had stool coming out of her colostomy and her rectum which was the wrong place. She stated when she wrote the order to send Resident #1 to the specialty hospital she meant for Resident #1 to be sent out to the hospital right then, like right away. She further stated if staff met an obstruction to send Resident #1 to the specialty hospital or if they had any questions about her orders, they should have called her back since she was in the facility for another 45 minutes to an hour after she saw Resident #1. She explained nurses could have also called the on-call physician to get clarification or orders to send her to any emergency room. The NP confirmed Resident #1 had a definite change in her vital signs on 03/11/14 and she remembered she specifically told Nurse #1 to send her out because she was not waiting to get labs because Resident #1 was metabolically unstable and was too sick to be there. She stated she was not aware Resident #1 was not sent out of the facility to a hospital until the next day.

During a follow up interview on 03/18/14 at 4:25 PM Nurse #1 confirmed she remembered the NP said Resident #1 needed be sent out. She stated when she saw the NP's order she thought the NP wanted Resident #1 to return to the specialty hospital to see the surgeon who did her previous surgery so she took the order to a 3:00 PM -11:00 PM supervisor and talked with her about it. She explained the supervisor told her the specialty hospital was not a regular hospital and did not have an emergency room and they would

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have to make an appointment the next day for for her to go there. She stated she did not call the NP back for clarification after she talked with her supervisor. She further stated she told her supervisor about Resident #1's increased temperature and she had put her on oxygen throughout the course of the shift and was told by her supervisor to keep a close watch on Resident #1 and to be sure to fill out the Stop and Watch Early Warning Tool and report to the oncoming shift so they would be aware of her condition.

During an interview on 03/18/14 at 4:38 PM the 3:00 PM to 11:00 PM Nursing Supervisor explained she had been told a note was left for the NP requesting a rectal tube for Resident #1 but the NP said they could not use a rectal tube because Resident #1 had a history of fistulas and she needed to be evaluated to find out why she was having stool through her colostomy and from her rectum. She explained during the evening of 03/11/14 Nurse #1 showed her the NP order and she told Nurse #1 they would have to wait till the next morning to call the facility to arrange for Resident #1 to see a surgeon. The nursing supervisor confirmed she was told by Nurse #1 that Resident #1 had a high pulse but she did not remember anything about an elevated temperature or low oxygen saturation percentages. She stated she and Nurse #1 did not discuss sending Resident #1 to the hospital that night and she did not see Resident #1 during the 3:00 PM to 11:00 PM shift on 03/11/14 because there was no reason to see Resident #1 based on what she had been told.

During an interview on 03/19/14 at 6:35 AM with NA #1 he confirmed he was assigned to Resident #1 during the 11:00 PM shift - 7:00 AM shift on

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03/11/14 - 03/12/14 before the resident was sent to the hospital. He stated they had to keep a close check on Resident #1 because she was having bowel movements from her rectum and the stool was getting in the dressing that covered a large wound on her bottom.

During an interview on 03/19/14 at 6:48 AM Nurse #2 explained Nurse #3 who was Resident #1's assigned nurse on the 11:00 PM to 7:00 AM shift called her to assist with wound care the night before Resident #1 was sent out of the facility to the hospital. She stated they did the wound care on 03/12/14 around 3:00 or 4:00 AM that morning and Resident #1 had a very large wound on her bottom and was having bowel movements from her rectum and they were worried that stool was getting into the wound. She explained Nurse #2 told her Resident #1 was supposed to be sent to a specialty hospital in the morning but she knew the specialty hospital did not have an emergency room and they would not take a resident back unless it was arranged in advance and it could take all day for them to accept or reject admission of the resident. She stated since she was not assigned to Resident #1's care she did not question Nurse #3 about it.

During an interview on 03/19/14 at 8:45 AM Nurse #4 explained she was the day shift nurse assigned to Resident #1 on 03/12/14 and got a shift report from Nurse #3 between 6:45 AM and 7:00 AM. She stated she was told Resident #1 was seen by the NP on the 3:00 PM - 11:00 PM shift and wanted Resident #1 to go back to the specialty hospital. She stated there were concerns about sepsis, increased stools from her rectum even though she had a colostomy, rapid heart rate and possible dehydration. Nurse #4

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stated she explained to Nurse #3 she had concerns about sending Resident #1 to the specialty hospital because she didn't think they took residents back after they had been discharged from there so she picked up the phone and called the specialty hospital and spoke with a nurse because the admissions department was not open. She stated the nurse told her it would be unusual for them to accept Resident #1 back to their facility and she would have to talk to her supervisor. Nurse #3 further stated she did not feel comfortable waiting for the specialty hospital to call her back because she had concerns about Resident #1's rapid heart rate, fever, dehydration, and possible sepsis. She stated she called her supervisor who was also the Assistant Director of Nursing (ADON) and reported her concerns about Resident #1's condition and then sent Resident #1 to the hospital.

During an interview on 03/19/14 at 9:39 AM the wound care nurse explained Resident #1 was admitted from a specialty hospital with a massive stage 4 wound that extended across both buttocks and sacral area. She explained they changed her dressings on a daily basis and she had a colostomy because of the wound. She further explained Resident #1 had some leakage of stool from her rectum when she was admitted but it became a challenge because the stools increased from her rectum. She stated on Monday 03/10/14 she spoke with Resident #1's physician because she was trying to come up with something to keep the stool out of the wound and suggested a rectal tube or some type of collection bag. She explained the stool from her rectum had increased to the point she was having more stools from her rectum than the amount of

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CHARLOTTE	4801 RANDOLPH RD CHARLOTTE, NC 28211

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stool that collected in the colostomy bag.

During an interview on 03/19/14 at 10:12 AM Nurse #3 verified she was assigned to care for Resident #1 from 11:00 PM - 7:00 AM shift on 03/11/14 - 03/12/14. She explained Nurse #1 told her in the shift report that the NP had seen Resident #1 on 03/11/14 and Nurse #1 had initiated a stop and watch form because Resident #1 had a rapid heart rate and her oxygen saturation percentages were low and she had started oxygen. She stated Nurse #1 told her the NP told her Resident #1 needed to go back to the specialty hospital to see her doctors who had seen her before and the second shift supervisor had printed off the NP order and had written a note for the day shift nurse to get the resident admitted in the morning. Nurse #2 verified she documented Resident #1's vital signs on the stop and watch form at midnight on 03/12/14 when her temperature was 99.4 degrees F and her oxygen saturation percentage was 96 percent on oxygen. She further verified Resident #1's temperature increased to 100.6 degrees F at 3:00 AM and her oxygen saturation percentage was 95 and her blood pressure was 86/52, respirations were 22 and her pulse was 134 - 144 and was irregular. She stated they changed the dressing on Resident #1's bottom during the night because it was soiled with stool and even though she had a colostomy most of the stool was coming from her rectum. She verified she did not call the physician on call since the NP had already assessed her and she did not want to overstep the doctor's orders that had been written to send her to the specialty hospital. She confirmed she did not read the NP progress note.

During an interview on 03/19/14 at 10:58 AM the

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ADON verified she was not called during the evening shift on 03/11/14 or during the night shift on 03/12/14. She stated the first call she received was a telephone call as she was driving to work from Nurse #4. She stated Nurse #4 told her about Resident #1's condition and the NP order to send Resident #1 to the specialty hospital. She stated she instructed Nurse #4 to call the physician and when she arrived at the facility emergency medical services was there to transport Resident #1 to the hospital.

During a phone interview on 03/20/14 at 11:47 AM with Resident #1's physician he explained he only saw Resident #1 once or twice in the facility since she was there only a short time but he was aware the NP saw her. He stated the wound care nurse had mentioned to him that Resident #1 had stools from her rectum and colostomy but he didn't think much about it at the time. He explained the wound nurse asked him about using a rectal tube but he didn't think it would work. He stated he was not aware Resident #1 had an increase in stools from her rectum and he was not notified about her abnormal vital signs on 03/11/14 through 03/12/14. He stated it was his expectation for staff to report a trend of increased stools from Resident #1's rectum over a 2 to 3 day period and if they increased it would have gotten his attention to order x-rays or medical consults to see what was causing them. He stated he did not know why Resident #1 was having stools from her rectum but it could have been something was not connected properly or she had a fistula. He further stated wound care was their main focus to keep the wound clean in order for it to heal. He also stated it was his expectation for nursing staff to report changes in condition or abnormal vital signs to him or the NP

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F 309	Continued From page 26 or the physician on call. During a follow up interview on 03/20/14 at 2:09 PM the wound care nurse explained when Resident #1 was admitted to the facility she was told the colostomy was new and was not aware it had been there since early January 2014. She clarified when Resident #1 was admitted she had a minimal amount of liquid stool from her rectum that was enough to wipe off with a gauze pad but was not formed stools and it did not occur every day. She stated she noticed Resident #1 was having a large amount of stool from her rectum on Monday 03/10/14 and it alarmed her and she spoke to the physician about using a rectal tube or some type of bag to collect the stool but he didn't think either of those options would work. She stated she did not have any additional conversations with the physician about the increased stools. During a second follow up interview on 03/20/14 at 3:45 PM Nurse #1 stated when she came to work on Monday 03/10/14 it was reported to her that Resident #1 was having more stools from her rectum. She also verified she did not go with the NP when she went to Resident #1's room and examined her and stated she had never gone with the NP to a resident's room when she examined residents. Nurse #1 explained she was at the nurse's station after the NP saw Resident #1 and the NP was talking out loud and said they needed to send her back or send her out. She further explained the NP stated out loud that Resident #1 had a history of fistulas and she wanted it checked out. She stated after the NP left she looked at her order and it seemed that what she said was what she wrote on the order and thought she wanted Resident #1 to see her	F 309		

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previous surgeon so she didn't question it and talked with her supervisor to arrange for Resident #1 to the specialty hospital the next day.

During a telephone interview on 03/21/14 at 9:14 AM with Resident #1's responsible party she stated she received a phone call during the morning on 03/12/14 from Nurse #4. She stated Nurse #4 told her they wanted to send Resident #1 back to the specialty hospital because something was different but she told Nurse #4 to send her to the hospital emergency room right then.

During an interview on 03/21/14 at 9:48 AM the Director of Nursing stated it was her expectation for nurses to obtain vital signs, monitor residents and notify the physician when a resident had a change in condition. She further stated it was her expectation when nurses had a question about a physician's order they should call for clarification about the order.

The facility's Administrator and Director of Nursing were notified of Immediate Jeopardy on 03/19/14 at 2:33 PM for Resident #1. The facility provided a credible allegation of compliance on 03/21/14 at 1:15 PM. The following interventions were put into place by the facility to remove the Immediate Jeopardy.

CREDIBLE ALLEGATION OF COMPLIANCE FOR TO PROVIDE CARE AND SERVICES TO MAINTAIN WELL-BEING

Identified Incident of Immediate Jeopardy Identified
F309 Quality of Care

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Resident(s) Identified

Director of nursing in-serviced staff involved in alleged deficient practice one on one. Staff was in-serviced to clarify any orders regarding transfer to hospital. All licensed staff was in-serviced regarding clarification of transfer orders. Resident remains in hospital.

Other Residents with Potential to be affected by the Immediate Jeopardy Incident

· Current residents have potential to be affected by the alleged deficient practice to maintain well being of resident.
· Director of Nursing and/or Unit Managers reviewed charts of the facility on March 19, 2014, with a look back from February 7, 2014 (date of compliance for last recertification survey) through March 19, 2014. There were no residents identified with change of condition through review. The Director of Nursing and/or Unit Managers and Supervisors along with nursing staff made clinical rounds on all current residents utilizing stop and watch tool and chart reviews were conducted along with the clinical rounds and no residents with change of conditions were identified.
Notification of the Allegation of Immediate Jeopardy and actions taken:
· Medical Director will educate the Nurse Practitioner on 3/19/14, when patient has acute change of condition that could potentially require hospitalization to refer to the nearest hospital for evaluation. Director of Nursing and/or Unit Managers will begin educating nursing supervisors and licensed nursing staff on 3/19/14, regarding notification of physician and

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F 309	Continued From page 29 responsible party for change of condition and follow through of physician orders. No staff will be allowed to work until receiving In-service. Director of Nursing and/or Unit Supervisors began educating licensed nurses' on March 19, 2014 regarding use of SBAR (process of assessment and notification of change of condition) and Stop and Watch Program (process in which any nurse can identify a change of condition in a resident). All nurses were instructed to contact facility physician or on call physician for further clarifications. Any change of condition identified through Stop and Watch is documented on 24 hour report and the chart for review during morning meeting. Any change of condition will be immediately referred to Physician for review and physician orders are followed in a timely manner. Nursing Staff will not be permitted to work until in-services received. Completion Date March 21, 2014. In-service will be provided for all new licensed staff during orientation. We will continue to notify families and Physician promptly with changes in condition. Immediate Changes to Facility Systems: · Director of Nursing and/or Unit Managers will review all physician orders in daily operation/clinical meeting beginning March 20, 2014, for follow through of order and notification of responsible party. The Director of Nursing and/or Unit Managers will review all orders in daily operation/clinical meeting beginning March 20, 2014, which includes residents with change of condition as determined by licensed staff, to assure Physician and responsible party notification. Any negative findings found by Licensed Nurses will be reported to Physician in timely manner. Immediate jeopardy was removed on 03/21/14 at	F 309		

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F 309	Continued From page 30 1:15 PM when interviews with nursing staff revealed awareness of expectations to assess residents who had changes in condition and to obtain medical interventions for the resident. They explained they had been in-serviced in new change of condition forms titled Situation, Assessment Background and Request (SBAR) and they were expected to complete them fully when a resident had a change in condition. They explained they would also continue to use the Stop and Watch Early Warning Tools because any staff member could initiate those when a resident had a had a change in their condition and they were expected to document the resident's condition on the 24 hour reports. They stated they had also been in-serviced to clarify orders when residents were transferred and when they had a question about a physician order to call for clarification immediately and document the information in the resident's medical record.	F 309		