

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

PRINTED: 04/11/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345415	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/19/2014
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NAME OF PROVIDER OR SUPPLIER  PINEVILLE REHABILITATION AND LIVING CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 LAKEVIEW DRIVE PINEVILLE, NC 28134
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F 309 SS=D	<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 medical record review and interviews with staff the facility failed to implement the facility bowel protocol for 1 of 3 sampled residents reviewed for regularity of bowel movements. (Resident #20)</p> <p>The findings included:</p> <p>Resident #20 was initially admitted to the facility 01/26/09 with diagnoses which included quadriplegia, traumatic brain injury and constipation. Resident #20 was hospitalized from 01/24/14 through 02/03/14 with discharge diagnoses including fecal impaction with massive accumulation of stool.</p> <p>Review of the current care plan for Resident #20 noted a care plan problem in place since 12/6/10 for incontinence, potential for skin breakdown infection related to neuromuscular impairment. Approaches to this problem area included, promote bowel regularity.</p> <p>On readmission from the hospital on 02/03/14 Resident #20 did not have any orders for laxatives. On 02/11/14 a physician's order was</p>	F 309	<p>F309</p> <p>The facility does assess, monitor, evaluate and accurately document the effectiveness of pain medication for its residents.</p> <p>RESIDENT IDENTIFIED</p> <p>1. R20□s was treated and had a BM on 3/20/14</p> <p>IDENTIFYING OTHER RESIDENTS AT RISK</p> <p>1. On 3/20/14 the facility ran a complete BM audit going 3 days back. Any resident that was identified as not having a BM was treated per protocol until a BM occurred. This was completed by the 2nd shift supervisor.</p> <p>PROCESSES IMPLMENTED TO PREVENT FURTHER OCCURRENCES</p> <p>1. The department heads were in-serviced on 3/20/14 on the new BM process that includes a 3 day look back. This was done for each unit</p> <p>2. The 2nd shift supervisor then started</p>	4/2/14
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/02/2014

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 309	<p>Continued From page 1</p> <p>written for Docusate Sodium (a stool softner) twice a day. Signed nursing protocol standing orders in the medical record of Resident #20 included the following for constipation: Assess bowel movement records in ECS (the facility electronic record). If not bowel movement after 2 days on 3rd day administer Milk of Magnesium (MOM) 30 cc (cubic centimeter) orally. Check for fecal impaction. If impaction present, administer fleets enema. If no results, notify physician.</p> <p>Review of the bowel records for Resident #20 as recorded in the ECS electronic nursing assistant record revealed no bowel movements from 03/02/14-03/18/14.</p> <p>Physician orders included orders on 03/12/14 for MOM 30 cc and an order on 03/13/14 for fleets enema related to constipation. Review of the 2014 March Medication Administration Record (MAR) for Resident #20 revealed the MOM and enema were administered to Resident #20 as ordered.</p> <p>On 03/18/14 at 5:11 PM Nurse # 2 reported the facility did not have a formal system in place to monitor resident bowel movements which was confirmed at the time of the interview by the DON. Nurse # 2 stated nurses were dependent on nursing assistants to report any extended times a resident went without a bowel movement and this would be shared with nurses via the 24 hour shift report. Nurse # 2 stated the three areas in the medical record bowel movements would be recorded were nursing assistant documentation in the ECS electronic system, nurses notes in the ECS electronic system and nurses notes in an additional (COMS) electronic</p>	F 309	<p>then started this new process on 3/20/14 and educated the staff on the process which included documentation of BM results.</p> <p>3. These BM logs were then reviewed by the IDT starting on 3/20/14 to ensure compliance.</p> <p>4. The Nurses and CNA's were educated by the Director of Nursing on 3/26 and 3/30/14 on the following:</p> <p>a) The state citation that was received</p> <p>b) The Facility's Charting and Documentation requirements.</p> <p>c) The facility's new BM monitoring policy</p> <p>d) The 1st shift nurse will print the BM log and treat with MOM (or PRN laxative) and document results, if no BM occurred this BM log will be passed on to 2nd shift for a suppository. If there is no BM on 2nd shift this BM log will be passed on to 3rd shift. 3rd shift will then treat with a enema. If no results occur then the MD will be notified.</p> <p>e) These BM logs will then be turned into the DON for review.</p> <p>5. These BM logs will be reviewed at the daily Nursing Quality Assurance Committee meeting for compliance.</p> <p><b>MONITORING</b></p> <p>1. On 4/2/14 the DON ran a complete 100% BM audit of the facility. From this audit it was identified that the facility staff was following the policy as implemented.</p> <p>2. All BM logs will be reviewed at the daily Nursing Quality Assurance committee meeting. At that time the team will ensure that all residents that did not</p>		

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F 309	<p>Continued From page 2</p> <p>system. Nurse # 2 shared how nurses enter information in the COMS system noting it was a comprehensive review of all health systems, including gastrointestinal. Nurse #2 noted COMS notes included daily notes if the resident was continent or incontinent and if the bowel was normal or not.</p> <p>The COMs electronic system was reviewed and included an extensive assessment of all body functions including gastrointestinal. The gastrointestinal section included sections titled, gastrointestinal, rectal bleeding, assessment of bowel sounds in all four quadrants, bowel continence, date of last BM, stool color and antibiotic for gastrointestinal infection. For each of these sections there were responses that the nurse completing the assessment checked. Under bowel incontinence the choices included "continent", "incontinent", "new incontinence", "colostomy" and "ileostomy". Under stool color the choices included "within normal limits", "tarry", "blood streaks/melena", "fatty" and "chalky".</p> <p>Nurses notes in the ECS and COMS electronic system were reviewed from 03/01/14-03/19/14. Nurses notes during this time frame in the ECS system did not mention any issues related to bowels with Resident #20. Review of the 24 hour nurses reports from 03/01/14-03/18/14 did not include any notations related to concerns with bowels for Resident #20. Notes in the COMS electronic system for Resident #20 under the gastrointestinal assessment included the following: 03/01/14-stool color-within normal limits; last bowel movement-not noted 03/02/14-stool color-within normal limits; last bowel movement-not noted</p>	F 309	<p>have a BM for 3 days were treated and results occurred. Any discrepancies noted will be immediately corrected and formal disciplinary action will occur.</p> <p>3. This Quality Assurance Plan will be a permanent practice for the facility.</p> <p>4. In-servicing for nursing staff will be conducted at least quarterly. These in-services will include the facility's Policy on; Change of condition, documentation, reporting and communication.</p> <p>5. The Medical Director has reviewed the Plan of corrections and has accepted it. The facility will continue to seek guidance and support from the Medical Director on the facility practices.</p> <p>The Director of Nursing/designee is responsible for Compliance. The facility will be in substantial compliance on 4/2/13</p>		

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F 309	<p>Continued From page 3</p> <p>03/03/14-incontinent; stool color-within normal limits; date of last bowel movement-03/02/14</p> <p>03/04/14-incontinent; stool color-within normal limits; date of last bowel movement-03/02/14</p> <p>03/05/14-incontinent; stool color-within normal limits; date of last bowel movement-03/02/14</p> <p>03/06/14-incontinent; stool color-within normal limits; date of last bowel movement-not noted</p> <p>03/07/14-continent; stool color-within normal limits; date of last bowel movement-not noted</p> <p>03/08/14-incontinent; stool color-within normal limits; date of last bowel movement-not noted</p> <p>03/09/14-incontinent; stool color-within normal limits; date of last bowel movement-not noted</p> <p>03/10/14-incontinent; stool color-within normal limits; last bowel movement-not noted</p> <p>03/11/14-incontinent; date of last bowel movement-03/11/14</p> <p>03/12/14-incontinent; stool color-within normal limits; last bowel movement-not noted</p> <p>03/13/14-incontinent; stool color-within normal limits; last bowel movement-not noted</p> <p>03/14/14-incontinent; stool color-within normal limits; last bowel movement-03/14/14. Resident has large bowel movement from enema given early AM by night shift.</p> <p>03/15/14-no notes found for this date</p> <p>03/16/14-stool color-within normal limits; last bowel movement-not noted</p> <p>03/17/14-incontinent; stool color-within normal limits; last bowel movement-not noted</p> <p>03/18/14-incontinent; stool color-within normal limits; last bowel movement-not noted</p> <p>On 03/19/14 at 12:55 PM Nurse #3 (that contributed to 13 of the nurses notes in COMS for Resident #20 during the period 03/01/14-03/18/14) stated when she completed the COMS assessment she noted "incontinent"</p>	F 309		
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F 309	<p>Continued From page 4</p> <p>and "stool color within normal limits" based on the individual residents normal. Nurse #3 stated it did not indicate that the resident had a bowel movement. Nurse #3 stated she was not sure when Resident #20's last bowel movement was but since working the current week she knew Resident #20 did not have a bowel movement on 03/17/14 and 03/18/14. Nurse #3 stated because she did not work 03/15/14 and 03/16/14 she did not know when the last bowel movement was for Resident #20. Nurse #3 stated she has just informed the nurse practitioner of Resident #20 that the nursing assistants reported no bowel movements 03/17/14 and 03/18/14. Nurse #3 stated the standing orders for constipation were implemented after three days without a bowel movement but it was contingent on nurses receiving reports from the nursing assistants about any concerns related to a residents bowel movements.</p> <p>On 03/19/14 at 4:30 PM Nurse #4 (that contributed to 10 of the nurses notes in COMS for Resident #20 during the period 03/01/14-03/18/14) stated when she completed the COMS assessment she noted "incontinent" and "stool color within normal limits" based on the individual residents normal. Nurse #4 stated it did not indicate that the resident had a bowel movement. Nurse #4 stated she did not know when Resident #20's last bowel movement was but if known it would be included in the COMS note under "last bowel movement". Nurse #4 stated nurses rely on nursing assistants to know if there are any concerns with a residents bowel movements. Nurse #4 stated on 03/12/14 she thought to check the nursing assistant documentation in ECS to see when the last time Resident #20 had a bowel movement. Nurse #4</p>	F 309			

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F 309	Continued From page 5 stated when she saw the last bowel movement recorded was 03/02/14 she implemented the standing orders including the MOM and enema. Nurse #4 stated she was not aware Resident #20 had not had a bowel movement since 03/14/14.  On 03/19/14 at 4:22 PM the Director of Nursing (DON) stated the expectation was that standing orders would be followed as ordered; including for constipation. The DON verified the nursing assistant charting in ECS indicated Resident #20 did not have a bowel movement from 03/02/14-03/19/14 but thought when nurses recorded "stool color within normal limits" and "incontinent" in COMS it meant the resident had a bowel movement. The DON stated not being aware staff were charting based on the normal for a resident. The DON stated the nurses relied on nursing assistants to inform them if residents had gone an extended time without a bowel movement and the facility did not have any other system in place to monitor residents bowel movements.	F 309			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced	F 314		4/2/14	

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F 314	<p>Continued From page 6</p> <p>by: Based on observation, record review, staff, and resident interviews, the facility failed to follow written physician orders for treatment of a pressure ulcer for 1 of 3 sampled residents. (Resident # 140).</p> <p>The findings included:</p> <p>Resident # 140 was re-admitted to the facility on 12/30/13 with a diagnosis of osteoarthritis.</p> <p>A review of the most recent Minimum Data Set (MDS) dated 03/18/14 indicated resident # 140 was cognitively intact and further revealed a stage 1 unhealed pressure ulcer.</p> <p>A record review of care plan dated 03/28/13 revealed a potential problem for impairment of skin integrity. Interventions included heel protectors, skin assessment as scheduled, and notify physician as needed.</p> <p>A record review of physician wound care order dated 02/20/14 revealed skin prep to be discontinued and a new order for foam dressing.</p> <p>On 03/19/14 at 8:47 AM observed that Nurse #1 gathered wound care supplies from the treatment cart to provide wound care for resident # 140. Nurse # 1 removed sock from resident # 140's right foot. Right heel lacked a dressing. Nurse # 1 applied wound cleanser, followed by skin prep to resident # 140's right heel. Nurse # 1 covered right heel with the sock that resident # 140 had previously worn.</p> <p>On 03/19/14 interview at 9:00 AM with Nurse # 1 revealed that she prints off the MAR in the</p>	F 314	<p>F 314</p> <p>The facility does ensure that residents who are admitted to the facility without pressure sores do not develop pressure sores.</p> <p>RESIDENT IDENTIFIED AND IDENTIFYING OTHER RESIDENT AT RISK</p> <ol style="list-style-type: none"> <li>1. R140's wound MD responded and the TX order was changed as ordered. A Med error report was completed.</li> <li>2. The wound Nurse was educated on following MD orders on 3/20/14 by the DON.</li> <li>3. No other residents were listed or cited for this in the sample mix.</li> </ol> <p>PROCESSES IMPLEMENTED TO PREVENT FURTHER OCCURENCES</p> <ol style="list-style-type: none"> <li>1. All Nurse managers were in-serviced by the DON on 3/20/14 on the following: <ul style="list-style-type: none"> <li>" Wound care protocols.</li> <li>" Preventative measures</li> <li>" Following MD orders</li> </ul> </li> <li>2. All direct care staff were in-serviced on 3/26 and 3/30/14 by the DON on the following : <ul style="list-style-type: none"> <li>" Wound care protocols.</li> <li>" Preventative measures</li> <li>" Following MD orders</li> </ul> </li> <li>3. On 3/20/14 the Nurse Managers were assigned the duties of completing a Medication and 1 treatment observation Mon-Fri. (5 total audits per week).</li> </ol>		

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F 314	Continued From page 7 morning before she starts wound care and checks for any new orders. Further interview with Nurse # 1 revealed that she thought she had a different physician order for skin prep.  On 03/19/14 interview at 2:05 PM with Director of Nursing (DON) revealed that expectations of wound care would be for nurses to follow physician order.	F 314	MONITORING 1. These QA tools will continue to be completed as set forth until substantial compliance is obtained. 2. At that time the QA committee will reconvene and the QA monitoring tools schedule will be modified to 3 QA tool□s weekly times 4 weeks, then 1 QA tool completed weekly thereafter. 3. The Nurse Managers will immediately document (on the QA tool) and correct any deficient practice that is identified during these QA rounds. 4. These QA tools will be turned into the DON as they are completed for review. 5. Further education, guidance and disciplinary action will occur for discrepancies noted. 6. These QA tools will be reviewed and added to the Quarterly QA Committee for further compliance. 7. The Medical Director has reviewed these POC□s. The facility will continue to seek guidance and direction from the Medical Director.  The DON is responsible for compliance. The facility will in compliance on 4/2/14		



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F 000	INITIAL COMMENTS	F 000		
{F 309} SS=D	<p>On 03/19/14, the Division of Health Service Regulation, Nursing Home Licensure and Certification Section conducted a revisit. While some of the deficiencies cited on the recertification survey on 01/16/14 were corrected effective 03/19/14, the facility remains out of compliance due to a re-citation at F309 and a citation at F314 on a complaint investigation.</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 medical record review and interviews with staff the facility failed to implement the facility bowel protocol for 1 of 3 sampled residents reviewed for regularity of bowel movements. (Resident #20)</p> <p>The findings included:</p> <p>Resident #20 was initially admitted to the facility 01/26/09 with diagnoses which included quadriplegia, traumatic brain injury and constipation. Resident #20 was hospitalized from 01/24/14 through 02/03/14 with discharge diagnoses including fecal impaction with massive accumulation of stool.</p>	{F 309}	<p>Res #1 DC home 1/20/14, Res #140, 8, 178 still remain in facility; all res assessed for eye infection, licensed nurses and NAs in-serviced on reporting SBAR/CiC; SBARs will be reviewed q wk by DON to ensure all CiC have been acted upon; results of monitoring will be presented to QA q month</p> <p>F309 The facility does assess, monitor, evaluate and accurately document the effectiveness of pain medication for its residents.</p>	4/2/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{F 309}	<p>Continued From page 1</p> <p>Review of the current care plan for Resident #20 noted a care plan problem in place since 12/6/10 for incontinence, potential for skin breakdown infection related to neuromuscular impairment. Approaches to this problem area included, promote bowel regularity.</p> <p>On readmission from the hospital on 02/03/14 Resident #20 did not have any orders for laxatives. On 02/11/14 a physician's order was written for Docusate Sodium (a stool softner) twice a day. Signed nursing protocol standing orders in the medical record of Resident #20 included the following for constipation: Assess bowl movement records in ECS (the facility electronic record). If not bowel movement after 2 days on 3rd day administer Milk of Magnesium (MOM) 30 cc (cubic centimeter) orally. Check for fecal impaction. If impaction present, administer fleets enema. If no results, notify physician.</p> <p>Review of the bowel records for Resident #20 as recorded in the ECS electronic nursing assistant record revealed no bowel movements from 03/02/14-03/18/14.</p> <p>Physician orders included orders on 03/12/14 for MOM 30 cc and an order on 03/13/14 for fleets enema related to constipation. Review of the 2014 March Medication Administration Record (MAR) for Resident #20 revealed the MOM and enema were administered to Resident #20 as ordered.</p> <p>On 03/18/14 at 5:11 PM Nurse # 2 reported the facility did not have a formal system in place to monitor resident bowel movements which was</p>	{F 309}	<p>RESIDENT IDENTIFIED</p> <ol style="list-style-type: none"> <li>1. R20□s was treated and had a BM on 3/20/14</li> </ol> <p>IDENTIFYING OTHER RESIDENTS AT RISK</p> <ol style="list-style-type: none"> <li>1. On 3/20/14 the facility ran a complete BM audit going 3 days back. Any resident that was identified as not having a BM was treated per protocol until a BM occurred. This was completed by the 2nd shift supervisor.</li> </ol> <p>PROCESSES IMPLMENTED TO PREVENT FURTHER OCCURRENCES</p> <ol style="list-style-type: none"> <li>1. The department heads were in-serviced on 3/20/14 on the new BM process that includes a 3 day look back. This was done for each unit</li> <li>2. The 2nd shift supervisor then started then started this new process on 3/20/14 and educated the staff on the process which included documentation of BM results.</li> <li>3. These BM logs were then reviewed by the IDT starting on 3/20/14 to ensure compliance.</li> <li>4. The Nurses and CNA□s were educated by the Director of Nursing on 3/26 and 3/30/14 on the following:             <ol style="list-style-type: none"> <li>a) The state citation that was received</li> <li>b) The Facility□s Charting and Documentation requirements.</li> <li>c) The facility□s new BM monitoring policy</li> <li>d) The 1st shift nurse will print the BM log and treat with MOM (or PRN laxative) and document results, if no BM occurred this BM log will be passed on to 2nd shift</li> </ol> </li> </ol>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345415	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R 03/19/2014
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{F 309}	<p>Continued From page 2</p> <p>confirmed at the time of the interview by the DON. Nurse # 2 stated nurses were dependent on nursing assistants to report any extended times a resident went without a bowel movement and this would be shared with nurses via the 24 hour shift report. Nurse # 2 stated the three areas in the medical record bowel movements would be recorded were nursing assistant documentation in the ECS electronic system, nurses notes in the ECS electronic system and nurses notes in an additional (COMS) electronic system. Nurse # 2 shared how nurses enter information in the COMS system noting it was a comprehensive review of all health systems, including gastrointestinal. Nurse #2 noted COMS notes included daily notes if the resident was continent or incontinent and if the bowel was normal or not.</p> <p>The COMs electronic system was reviewed and included an extensive assessment of all body functions including gastrointestinal. The gastrointestinal section included sections titled, gastrointestinal, rectal bleeding, assessment of bowel sounds in all four quadrants, bowel continence, date of last BM, stool color and antibiotic for gastrointestinal infection. For each of these sections there were responses that the nurse completing the assessment checked. Under bowel incontinence the choices included "continent", "incontinent", "new incontinence", "colostomy" and "ileostomy". Under stool color the choices included "within normal limits", "larry", "blood streaks/melena", "fatty" and "chalky".</p> <p>Nurses notes in the ECS and COMS electronic system were reviewed from 03/01/14-03/19/14. Nurses notes during this time frame in the ECS system did not mention any issues related to</p>	{F 309}	<p>for a suppository. If there is no BM on 2nd shift this BM log will be passed on to 3rd shift. 3rd shift will then treat with a enema. If no results occur then the MD will be notified.</p> <p>e) These BM logs will then be turned into the DON for review.</p> <p>5. These BM logs will be reviewed at the daily Nursing Quality Assurance Committee meeting for compliance.</p> <p><b>MONITORING</b></p> <ol style="list-style-type: none"> <li>On 4/2/14 the DON ran a complete 100% BM audit of the facility. From this audit it was identified that the facility staff was following the policy as implemented.</li> <li>All BM logs will be reviewed at the daily Nursing Quality Assurance committee meeting. At that time the team will ensure that all residents that did not have a BM for 3 days were treated and results occurred. Any discrepancies noted will be immediately corrected and formal disciplinary action will occur.</li> <li>This Quality Assurance Plan will be a permanent practice for the facility.</li> <li>In-servicing for nursing staff will be conducted at least quarterly. These in-services will include the facility's Policy on; Change of condition, documentation, reporting and communication.</li> <li>The Medical Director has reviewed the Plan of corrections and has accepted it. The facility will continue to seek guidance and support from the Medical Director on the facility practices.</li> </ol> <p>The Director of Nursing/designee is responsible for Compliance.</p>	
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{F 309}	Continued From page 3 bowels with Resident #20. Review of the 24 hour nurses reports from 03/01/14-03/18/14 did not include any notations related to concerns with bowels for Resident #20. Notes in the COMS electronic system for Resident #20 under the gastrointestinal assessment included the following: 03/01/14-stool color-within normal limits; last bowel movement-not noted 03/02/14-stool color-within normal limits; last bowel movement-not noted 03/03/14-incontinent; stool color-within normal limits; date of last bowel movement-03/02/14 03/04/14-incontinent; stool color-within normal limits; date of last bowel movement-03/02/14 03/05/14-incontinent; stool color-within normal limits; date of last bowel movement-03/02/14 03/06/14-incontinent; stool color-within normal limits; date of last bowel movement-not noted 03/07/14-continent; stool color-within normal limits; date of last bowel movement-not noted 03/08/14-incontinent; stool color-within normal limits; date of last bowel movement-not noted 03/09/14-incontinent; stool color-within normal limits; date of last bowel movement-not noted 03/10/14-incontinent; stool color-within normal limits; last bowel movement-not noted 03/11/14-incontinent; date of last bowel movement-03/11/14 03/12/14-incontinent; stool color-within normal limits; last bowel movement-not noted 03/13/14-incontinent; stool color-within normal limits; last bowel movement-not noted 03/14/14-incontinent; stool color-within normal limits; last bowel movement-03/14/14. Resident has large bowel movement from enema given early AM by night shift. 03/15/14-no notes found for this date 03/16/14-stool color-within normal limits; last	{F 309}	The facility will be in substantial compliance on 4/2/13		

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{F 309}	<p>Continued From page 4</p> <p>bowel movement-not noted 03/17/14-incontinent; stool color-within normal limits; last bowel movement-not noted 03/18/14-incontinent; stool color-within normal limits; last bowel movement-not noted</p> <p>On 03/19/14 at 12:55 PM Nurse #3 (that contributed to 13 of the nurses notes in COMS for Resident #20 during the period 03/01/14-03/18/14) stated when she completed the COMS assessment she noted "incontinent" and "stool color within normal limits" based on the individual residents normal. Nurse #3 stated it did not indicate that the resident had a bowel movement. Nurse #3 stated she was not sure when Resident #20's last bowel movement was but since working the current week she knew Resident #20 did not have a bowel movement on 03/17/14 and 03/18/14. Nurse #3 stated because she did not work 03/15/14 and 03/16/14 she did not know when the last bowel movement was for Resident #20. Nurse #3 stated she has just informed the nurse practitioner of Resident #20 that the nursing assistants reported no bowel movements 03/17/14 and 03/18/14. Nurse #3 stated the standing orders for constipation were implemented after three days without a bowel movement but it was contingent on nurses receiving reports from the nursing assistants about any concerns related to a residents bowel movements.</p> <p>On 03/19/14 at 4:30 PM Nurse #4 (that contributed to 10 of the nurses notes in COMS for Resident #20 during the period 03/01/14-03/18/14) stated when she completed the COMS assessment she noted "incontinent" and "stool color within normal limits" based on the individual residents normal. Nurse #4 stated it</p>	{F 309}			

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{F 309}	<p>Continued From page 5</p> <p>did not indicate that the resident had a bowel movement. Nurse #4 stated she did not know when Resident #20's last bowel movement was but if known it would be included in the COMS note under "last bowel movement". Nurse #4 stated nurses rely on nursing assistants to know if there are any concerns with a residents bowel movements. Nurse #4 stated on 03/12/14 she thought to check the nursing assistant documentation in ECS to see when the last time Resident #20 had a bowel movement. Nurse #4 stated when she saw the last bowel movement recorded was 03/02/14 she implemented the standing orders including the MOM and enema. Nurse #4 stated she was not aware Resident #20 had not had a bowel movement since 03/14/14.</p> <p>On 03/19/14 at 4:22 PM the Director of Nursing (DON) stated the expectation was that standing orders would be followed as ordered; including for constipation. The DON verified the nursing assistant charting in ECS indicated Resident #20 did not have a bowel movement from 03/02/14-03/19/14 but thought when nurses recorded "stool color within normal limits" and "incontinent" in COMS it meant the resident had a bowel movement. The DON stated not being aware staff were charting based on the normal for a resident. The DON stated the nurses relied on nursing assistants to inform them if residents had gone an extended time without a bowel movement and the facility did not have any other system in place to monitor residents bowel movements.</p>	{F 309}			