

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

PRINTED: 10/14/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/19/2014
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NAME OF PROVIDER OR SUPPLIER CAROLINA RIVERS NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540
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F 000	INITIAL COMMENTS The Division of Health Service Regulation (DHSR), Nursing Home Licensure and Certification Section conducted a complaint investigation survey 09/17/2014 through 09/19/2014. It was decided that the facility had substandard quality of care at the immediate jeopardy level and a partial extended survey was conducted. The immediate jeopardy began on 09/12/2014 and was removed on 09/19/2014.	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 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	F 157		10/20/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/07/2014

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	<p>Continued From page 1 this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews and physician interviews, the facility failed to notify the primary physician of an emergent condition involving a resident bleeding from both ears, for 1 of 4 residents (Resident #1) reviewed for an acute change of condition. Immediate jeopardy began on 09/12/2014 when the resident was found to have a purple face, blue lips, bleeding out of both ears, a bruise on her face, and staff delayed calling for transport to the hospital for approximately five hours after the change in condition was recognized. The Administrator was notified of the Immediate Jeopardy on 9/18/14 at 7:41 PM. Immediate Jeopardy was removed on 09/19/2014 at 7:35 PM. The facility remained out of compliance at a lower scope and severity of (D) isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility completes the staff training required. The facility was in the process of monitoring the implementation of their corrective action. The findings included:</p> <p>Resident #1 was admitted to the facility on 04/18/2012 from an acute care hospital. Her cumulative diagnoses included multiple contractures, dysphagia, muscle weakness, anoxic brain damage, depression, cerebral artery occlusion with infarct, and asthma.</p>	F 157	<p>Carolina Rivers Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance.</p> <p>Carolina River's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Carolina Rivers reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution formal appeal procedure and/or any other administrative or legal proceeding.</p> <p>F157-MD Notification</p> <p>" Resident #1 was observed on 9/12/14 at approximately 6:30am by CNA (NA) with flushed skin and blood coming from resident ears. CNA notified nurse of resident flushed skin and blood coming</p>		

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F 157	<p>Continued From page 2</p> <p>The most recent Minimum Data Set (MDS) dated 6/19/14, indicated the resident had long and short term memory problems and decision making ability was severely cognitively impaired. The MDS indicated the resident was rarely or never understood, required total assistance for bed mobility, had contractures in both lower extremities and could not ambulate. According to the MDS, the staff assessment of the resident's mood did not indicate the presence of any symptoms of depression, mood disorder or behaviors.</p> <p>Documentation in Resident #1's record was reviewed for the events on 09/12/2014. An entry dated 09/12/2014 at 12:15 AM, indicated the resident was in bed with her eyes closed, that she was incontinent and required staff turning and repositioning. The entry stated there were no acute changes or signs of distress. The note was signed by Licensed Practical Nurse (LPN) #1.</p> <p>The next entry was dated 09/12/2014 at 6:51 AM and read, "CNA (Nursing Assistant) informed me that resident was bleeding out of her ears. Resident had blood coming out of her ears and her face was slightly purple." The note also stated the Resident's oxygen saturation level (O2 sat) was 92%. After the resident was given oxygen the O2 sat was 97%, the blood pressure was 134/58 and heart rate was 98. The note indicated the Director of Nursing (DON) was informed, a voicemail message had been left for the attending physician and the nurse was unable to reach the responsible party (RP) by phone. The note was signed by LPN#1.</p> <p>A physician's telephone order, dated 9/12/2014 at 11:48 AM stated Resident #1 was to be sent to</p>	F 157	<p>from resident #1 ears on 9/12/14. Nurse assessed resident #1 at approximately 6:45 am on 9/12/14 with O2 sats range at 92% and skin color slightly purple. Nurse applied O2 and sats went to 97%, blood pressure 134/58 and heart rate 98. Resident #1 was reassessed on 9/12/14 at approximately 7:00 am by the third shift and first shift nurse with no active bleeding noted. First shift nurse continued to assess resident #1 on 9/12/14 at 8:30 am with no active bleeding observed. First shift nurse reassessed resident #1 on 9/12/14 around 9:30 am and observed a rash on resident face and light discoloration to resident face. On 9/12/14 9:30am the MD (physician) office nurse was made aware by first shift nurse of bleeding from resident #1 ears at 6:30am, rash on face, and light discoloration to resident face. Resident #1 was assessed by first shift nurse again at approximately 10:30 am an observed darkening under resident's eyes. On 9/12/14 first shift nurse contacted MD office nurse again and notified of darkening under resident's eyes. Order received from MD office nurse on 9/12/14 approximately at 11:48am MD order was written to send resident to ER. Hall nurse assigned to resident #1 during the acute change was drug tested and suspended by the Administrator on 9/15/14. CNA assigned to resident #1 during the acute change in condition was suspended and drug tested by the Administrator on 9/16/14. An inservice was initiated on 9/12/14 and an additional inservice was initiated on 9/16/14 with both in-services completed at</p>		

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F 157	<p>Continued From page 3 the hospital emergency room for evaluation.</p> <p>At 12:05 PM on 09/12/2014 the progress note read, "Resident being assessed throughout the shift. No bleeding noted thus far, but a rashy area to upper face and dark circles to Bilat (both) eyes noted. Resident continues on 2L (2 liters) O2 via NC (nasal cannula). Resident grimacing more than usual. MD (physician) made aware. No answer at RP's number. DON made aware." This note was signed by LPN#2.</p> <p>A progress note dated 09/12/2014 at 12:15 PM read, "Resident being assessed throughout the shift. No bleeding noted thus far, but a rashy area to upper face and dark circles to Bilat eyes noted. Upon starting shift no black circle noted. Area around eyes appeared to slowly darken throughout the shift. Resident continues on 2L O2 via NC. Resident grimacing more than usual. MD made aware. No answer at RP's number. DON made aware." The note was signed by LPN#2.</p> <p>The hospital Emergency Department exam report dated 09/12/2014 included, "Patient with petechiae to face and ecchymosis around eyes, blood from ears. There are bruises along the patient's throat that are suspicious for finger prints. I am concerned about elder abuse and attempted strangulation. Will notify DSS (Department of Social Services) and plan to admit patient for her safety until this situation can be investigated. Pt (patient) is nonverbal but when I ask her if anyone hurt her, her eyes began to tear up." The report was signed by Hospital Physician #1.</p> <p>The Radiology report (dated 09/12/2014) revealed the Computerized Tomography (CT)</p>	F 157	<p>100% by 9/18/14 with all other licensed nurses by the Staff Facilitator (Staff Educator) to include LPN #1, LPN #2, LPN #3, and LPN #4 regarding assessing acute changes in condition, sending resident out if unable to contact MD, examples of acute changes to include abnormal bleeding, notification to physician by telephone when an acute change in condition to include cognitive status, behavior, immune system response, normal body system functioning, changes in cognitive status, changes in behavior, changes in oral intake to include fluids, changes in immune system, changes in normal body functioning, Panic laboratory values, resident's condition warrants based upon nurse's assessment; If you are unable to reach Attending Physician, you may call On-call for physician; If you are unable to reach attending or on-call physician, you may call the facility's Medical Director. Notification of the physician of these types of changes in a resident's condition by fax is not acceptable. Handouts given to staff for reference. No nurse will be allowed to work without first receiving the in-services.</p> <p>" Acute Change is defined as anything outside the norm for a resident to include but not limited to abnormal bleeding, skin color changes, changes in behaviors, change in mental alertness and orientation, increased weakness or fatigue, change in abilities to feed, bathe, or groom self, change is sitting balance, transfer, or walk, change in appetite,</p>		

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F 157	<p>Continued From page 4</p> <p>scan was negative for a fracture, there was no mass or hematoma and no other significant findings.</p> <p>During an interview on 09/19/2014 at 9:51 AM, Hospital Physician #1 discussed her findings regarding her examination of Resident #1 on the afternoon of 09/12/2014. Hospital Physician #1 said that in addition to the bruising around her eyes and on her neck, Resident #1 also had a bruise on her upper arm when she came into the emergency department (ED). Hospital Physician #1 said Resident #1 wasn't on any medications that would have caused the petechiae or bruising. Hospital Physician #1 said, "Very few things will cause that petechial rash. It is forensically distinctive,- pathognomonic [specifically characteristic of a disease or condition; denoting a sign or symptom on which a diagnosis can be made]." The physician further stated, "The petechial rash is indicative of strangulation or a crushing force. I could not find anything else that would have caused it with this patient."</p> <p>The documentation from Resident #1's admitting hospital physician (Hospital Physician #2) dated 09/12/2014 included, "Her face appears atraumatic except for large periorbital, infraorbital ecchymosis (bruising under and around the eyes).Patient has a petechial rash from the upper lip up to the forehead." The document also indicated there was a little bit of petechial rash "on the left side of the neck." Hospital Physician #2's assessment included, "Petechial rash. Is it a case of elderly abuse? We spoke with the nursing home staff and they truly do not have any idea of what happened. Patient is not ambulatory. She is totally bedridden so there was no history of a fall. This has to be investigated and DSS will be</p>	F 157	<p>change in ability to chew/swallow food, difficulty with breathing, complaints of dizziness, change in bowel elimination habits, complaints of nausea and vomiting, and falls.</p> <p>" 100% of all current residents were physically observed for acute changes in condition to include changes in skin color and bleeding on 9/15/14 by DON Director of Nurses), Staff Facilitator , QI (Quality Improvement) nurse, MDS (Minimum Data Set) nurses (2) and facility consultant. Four concerns were noted during this audit and corrected by the treatment nurse on 9/15/14 and 9/16/14 with interventions placed, MD and RP (resident representative) notification, and documentation in the progress notes. Three months of nurse's notes were reviewed to ensure all documented acute changes in condition to include changes in skin color and bleeding have been addressed with appropriate interventions placed, Attending Physician notification and Responsible Party notification of the acute change on 9/15/14 by DON, Staff Facilitator nurse, QI nurse, MDS nurses (2) and facility consultant. Two concerns were noted during this audit with reassessment of the resident by the treatment nurse on 9/16/14, no concerns observed during the reassessment, and documentation in the progress note.</p> <p>" An inservice was initiated with 100% of license nurses to include agency nurses and LPN #1, LPN #2, LPN #3, and LPN #4 initiated on 9/12/14, on</p>		

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F 157	<p>Continued From page 5 called."</p> <p>Hospital Physician #2 was interviewed on 09/18/2014 at 10:44 AM and said, "This patient has so many unexplained injuries. These were life-threatening injuries." When asked about possible causes for the bleeding from the ears, Hospital Physician #2 stated that bleeding from the ears was usually associated with a skull fracture or very forceful coughing. She further stated that petechiae is often found with strangulation or forceful vomiting and that the nursing home had said there was no vomiting. Hospital Physician #2 said that tests showed no cranial fracture but there was swelling of the soft tissue in her face and neck, bruising, and subconjunctival hemorrhaging. Hospital Physician #2 said, " I don't know of anything that could cause all of that other than strangulation when you rule out a fall, vomiting or forceful cough." Hospital Physician #2 indicated Resident #1 was still in the hospital.</p> <p>The facility provided their investigation and written statements from the facility staff taken on 09/15/2014 through 09/17/2014. After review of each written statement, the facility staff were interviewed during the survey.</p> <p>On 09/16/2014 Nursing Assistant (NA) #1 wrote, "(Resident #1) had no falls on 11-7 that I'm aware of in the last 2 wks (weeks)." During the survey, an interview was conducted with NA #1 on 09/18/2014 at 10:42 AM. NA#1 indicated she was working the 11 PM to 7 AM shift, had provided care for Resident #1, and was the person who discovered Resident #1 with bleeding ears. At approximately 6:40 AM, NA #1 looked in to check on the resident and found her with the</p>	F 157	<p>assessment of acute changes in condition, sending resident out if unable to notify MD, notification to physician by telephone to include second shift, third shift and weekends; when an acute changes in condition occur, including abnormal bleeding, changes in cognitive status, behavior, oral changes to include fluids, immune system response, normal body system functioning, Panic laboratory values, resident's condition warrants based upon nurse's assessment; If you are unable to reach Attending Physician, you may call On-call for physician; If you are unable to reach attending or on-call physician, you may call the facility's Medical Director. Notification of the physician of these types of changes in a resident's condition by fax is not acceptable. This in-service was 100% completed on 9/18/14 by Staff Facilitator. In-service was initiated on 9/18/14 and completed on 9/21/14 by Staff Facilitator with all license nurses to include LPN #1, LPN #2, LPN #3, and LPN #4 regarding Notifying the MD through the hospital after office hours and location of after-hours numbers. All newly hired licensed nurses and newly assigned agency staff will be in-serviced in orientation on notification to the physician of acute changes in resident condition and the after-hours notification of MD.</p> <p>" The staff nurse is responsible to assess, document, provide appropriate interventions and notify Attending Physician and Responsible Party of any acute changes in condition noted. On</p>		

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F 157	<p>Continued From page 6</p> <p>gown pulled up over her face. NA#1 said Resident #1 was facing the door, laying on her right side and her sheet was on the floor. NA#1 saw blood on sheet, and spots of blood, close together on the pillow in front of her face. I had no idea where the blood was coming from, so I went to look." NA #1 turned the resident on her back, "and the blood poured out of her (left) ear" so she turned her on her back and went to look for the nurse. NA#1 reported that neither of the nurses were available but the NA from the 100 hall was doing care and she motioned for her to come with her to Resident #1's room. NA#1 and NA#2 went back to the room and when NA#2 saw the resident she left to go get LPN#1. NA#1 stated that when she started to clean Resident #1 up and turned her over blood came out of the other ear.</p> <p>Nursing Assistant (NA) #2's undated statement included, "I got done caring for my residence(sic) and as I was making my way to the back nurses station I bumped into (NA#1) who said (Resident #1) was bleeding. As I enter the room I noticed that her face was blue and that their (sic) was blood in her ears." NA#2 was interviewed during the survey on 9/18/2014 at 5:20 PM, and said, "I was through with my rounds and saw (NA#2) was coming out of her room and she said (Resident #1) was bleeding and she didn't know why or where. So I followed into the room and her (Resident #1's) face was blue and we noticed her bleeding." NA#2 said, "I left to go find a nurse and she told me to get her vitals (vital signs)."</p> <p>On 09/15/2014 LPN#1 wrote, "Between the times of 6:30-6:45ish am, CNA came and told me that (Resident #1) had blood coming out of her ear and was slightly purple in her face. I ran to the</p>	F 157	<p>9/18/14 the after-hours MD notification number was posted at each nurse's station by the DON. If the staff nurse is unable to reach the attending physician, the on-call MD must be called. If unable to contact the attending or the on-call MD, the nurse must call the Medical Director. The staff nurse will implement appropriate interventions based on the needs of the resident and notify Attending Physician and Responsible Party. Staff will notify the DON or on-call nurse of any acute changes. DON, QI nurse, Staff facilitator and MDS nurses were in-serviced by the Administrator on 9/16/14 concerning when they are on-call and they receive a call concerning a change in condition of a resident that they are to ask more questions, if needed, to get a clear picture of what is occurring with the resident and to insure that the nurse has notified the MD of the acute change. A QI tool, Acute Change Call Log, will be used daily by the On-Call nurse and the Administrator will review weekly.</p> <p>The DON will determine if the acute change in condition reported by the hall nurse fits the definition of an injury of unknown origin-Injury of any type that occurs where the cause or contributing factor is not known or determined. If the acute change in condition fits the definition of an injury of unknown origin then the abuse/injury of unknown origin procedure will be followed to include: The procedure for all allegations of abuse and injury of unknown origin is as follows: Any employee accused of abuse will be</p>		

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F 157	<p>Continued From page 7</p> <p>room with my vital sign equipment. Her pulse was high and her O2 was in the low 90s after getting oxygen put on her at 2L resident's vitals were re-taken and after were good within normal limits." LPN#1 was interviewed during the survey on 09/18/2014 at 11:14 AM and said she had given the resident her scheduled medications (Synthroid and Prilosec) around 6AM and had not noticed any agitation at that time or earlier in the night. LPN#1 stated that the resident had not had problems during the night and no one had reported any fall or agitation with regard to Resident #1. When asked how she had learned of the resident's condition that morning LPN#1 said, "(NA#2) reported it to me. She said (Resident #1) was slightly purple in her face and she had blood coming out of her ear. I think it was her left ear. I got vital signs right away. She had blood coming out of her ear and she was purple in her face like she wasn't getting enough oxygen." When asked about the amount of blood coming from the resident's ears LPN#1 replied, "I would say it was like a nose bleed. It wasn't gushing but was actively flowing." LPN#1 stated that she called LPN#2 and #3. She indicated LPN #2 went to get the oxygen and the resident's oxygen saturation level "started to come up and color started to come back and the bleeding had stopped." LPN#2 said, "I called the DON and I told her everything that was going on, - the blood, purple and O2 and that her vital signs were okay. I called the doctor and left a message. The next nurse came on and I told her everything." When asked about what might cause bleeding from both ears, LPN#1 said, "I don't know."</p> <p>On 09/15/2014 LPN#2's statement included that LPN#1 had called for assistance and when she entered the resident's room the NAs were</p>	F 157	<p>immediately removed from resident care area to an office. The resident will be assessed by a license nurse and will document in the medical record. Corrective measures will be initiated immediately to protect the resident. Statements will be obtained from identified employee, if any, and any possible witnesses. Employee will be suspended immediately per policy pending outcome of investigation. The Administrator and/or DON will complete and send to RVP for prior approval and then fax the 24 hour report to the NCHCPR. Notification of law enforcement if applicable. Resident interviews will be conducted by the Admissions Coordinator with alert and oriented residents and physical assessments will be conducted for non-alert and oriented residents by license nurse. At the completion of the investigation the Administrator and/or the DON will submit a 5 day report to the NCHCPR. The Administrator is responsible to direct the investigation process and to ensure that the appropriate agencies, to include the NCHCPR, are notified per policy.</p> <p>Current residents will be physically observed for acute changes in condition, 24 hour/communication board will be reviewed, and nurse notes will be reviewed, using census as documentation, weekly X□s 4 weeks and then monthly X□s 3 months to insure that if resident has a change in condition that it the resident has been assessed, MD and</p>		

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F 157	<p>Continued From page 8</p> <p>changing the bed. "The ring of blood I saw was approximately four inches in diameter. (LPN#1 stated that resident was bleeding from her ears. Resident's lips were bluish tinged so I told (LPN#1) I would get oxygen." The statement indicated that LPN#2 told LPN#1 to call Resident #1's attending physician. LPN#2 was interviewed during the survey on 9/19/14 at 3:50 PM. LPN#2 said, "I did see blood, probably the size of a grapefruit, maybe 3-4 inches on the sheet or pillowcase. The resident's lips were a little blue tinged so I went to get some oxygen." LPN#2 said, "When (LPN#1) told me she couldn't get the doctor- that he didn't answer, I told her to call the DON." When asked if she told LPN #1 to call the hospital to contact the physician outside of regular office hours, LPN#2 indicated she only told her to call the doctor and added, "I can't tell you that I did tell her or that I didn't tell her on any prior occasion."</p> <p>LPN #3 provided a written statement for the facility on 09/17/2014. The statement included that when LPN#3 arrived at the 200 hall nursing station, LPN#1 told her that everything was okay. LPN#3 went into Resident #1's room and saw blood in her ear and on the pillowcase. LPN#3 was interviewed during the survey on 09/19/2014 at 4:15 PM. LPN#3 said that on the morning of 09/12/2014 she had been giving report when someone paged for all nurses to go to the 200 hall. "She (LPN#1) didn't call any kind of a code or anything so we just walked there." LPN#3 said that when she arrived at the nursing station, "(LPN#2) said 'That's okay, we got it.'" LPN#3 stated she went to Resident #1's room and saw blood in the resident's right ear. LPN## stated she did not do an assessment of the resident but did ask the NAs in the room what happened,</p>	F 157	<p>RP was notified timely, and any orders given were initiated timely utilizing an Acute Change in Condition Monitoring QI Tool. This will be completed by DON, QI nurse, staff facilitator, and/or MDS nurses. The Administrator will review the Acute Change in Condition Monitoring QI Tool weekly for 4 weeks the monthly for 3 months for accuracy and completion.</p> <p>Directed inservicing to be provided to all facility licensed nurses on all shifts to include change in condition and getting resident medical treatment. Inservicing will be provided in the facility by a MSN qualified instructor through Eastern Carolina AHEC on October 15, 2014.</p> <p>The Executive QI committee (Administrator, DON, QI, MDS, and any other appropriate persons) will meet weekly x 4 weeks and then monthly to review Acute Change in Condition Monitoring QI Tool to determine trends and/or issues that may need further interventions put in place. To determine that need for further and/or frequency of monitoring.</p>		

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F 157	<p>Continued From page 9</p> <p>"and they all said they didn't know." LPN#3 said she observed fresh blood, "about the size of a donut" on the linen and the resident was grimacing. She said, "I didn't know what to think" and added "I would have called the doctor and then called the DON and if the doctor didn't call back then I would have called the DON again."</p> <p>On 09/15/2014 the DON wrote that on 09/12/2014 at approximately 6:50 AM, "I received a call from (LPN#1). She stated that (Resident #1) had some blood coming out of her ears and she didn't know what to do. I said you need to call the doctor and make sure to call the R.P. (Responsible Party) as well. She stated okay. I got to the facility (approximately) 8:30 on 9/12/14 and I had not heard anything else regarding resident status until 7-3 nurse (LPN#4) stated that she had sent the resident to the ER for rash on face and dark circles forming under eyes." The DON was interviewed during the survey on 09/18/2014 at 5:35 PM, and said, "I got a phone call from (LPN#1) at about 6:45-6:50. She said (Resident #1) had blood from her ear and she didn't know what to do. I told her she needed to call the doctor and report it." The DON stated that she did not inquire further about the blood from the resident's ears and said, "I thought it was a skin tear or scratch or something. I didn't think it was anything emergent but I did tell her to call the doctor." The DON stated that a lot of blood from a resident's ears could be a sign of a head injury and said, "I would have expected her (LPN#1) to send her to the hospital when they saw the amount of blood I have since learned of." The DON said if the nurse did not hear back from the physician that the resident should have been sent to the hospital for evaluation. The DON said she learned that LPN#1 had called the physician's</p>	F 157			

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F 157	<p>Continued From page 10</p> <p>office and left a message on the answering machine. Upon request the DON reviewed the physician numbers posted at the nursing station and said the off-hours paging number for that doctor was not posted at the desk.</p> <p>LPN#4's undated statement indicated she was told by the off-going 11-7 nurse that Resident #1 had been bleeding from her ears. "The nurse mentioned to another that it was a lot. She attempted to get in touch with the resident's doctor but never talked to him." LPN#4's statement also included, "All the while in the back of my mind I'm thinking her doctor was paged at some point and he should be calling soon." The statement indicated LPN#4 had checked the resident at approximately 8:30 AM and there was no active bleeding from the ears and no other symptoms but about an hour later the resident had developed a rash around her eyes and there was some discoloration on her face. "I then called the MD's (physician's) office to see why they hadn't called and to tell them about the rash. I spoke with the MD's nurse and told her about the bleeding from the previous shift as well. She stated she would let him know and call back. Not even an hour later resident began to have dark circles under her eyes like blood had pooled there. I called the MD's office back to let them know and found out from the nurse that the MD said that he never received any pages or calls from anyone about the matter. I was instructed to send the resident out to the hospital for evaluation. Resident was alert with eyes open when she left. I was asked by MD's office if resident has sustained any falls but I was unaware of any recent falls." LPN#4 was interviewed during the survey on 09/18/2014 at 10:08 AM. She stated when she examined</p>	F 157			

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F 157	<p>Continued From page 11</p> <p>Resident #1 she didn't see any blood but there was a light purple discoloration on the right side of her face and the discoloration was on her forehead too. "I was waiting for the doctor to call back and I continued with my med-pass." LPN#4 stated that about one and a half hours later she checked the resident and the oxygen was still on at 2L per minute. She said the treatment nurse went in to change a dressing and identified the rash on the resident's face as petechiae. LPN#4 said she called the attending physician's nurse and then about an hour and a half later she noted the dark circles forming under her eyes and called the physician's office again. The resident went out to the hospital at approximately noon. LPN#4 said, "I thought she had fallen when her eyes started to turn black but night shift said she had not fallen and she was in bed all day for us and I know she didn't have a fall. I was thinking closed head injury or that she had fallen." She added, "I called the DON to tell her I was sending (Resident #1) out."</p> <p>During an interview on 09/19/2014 at 5:15 PM, the Administrator said, "The physician should have been notified immediately and the resident sent out."</p> <p>During an interview on 09/25/2014 at 9:11 AM, Resident #1's attending physician in the facility stated, "I was informed that the day nurse had been waiting for a call back from me but I didn't know anything about an earlier call about the bleeding from both ears earlier." The physician said, "I would expect the nurse to send her to the hospital to see why she was bleeding from the ears." He added, "This (bleeding from the ears) was definitely an emergency."</p>	F 157			

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F 157	<p>Continued From page 12</p> <p>The Administrator was notified of the Immediate Jeopardy for F309 on 9/18/14 at 7:41 PM.</p> <p>The facility provided the following credible allegation of compliance on 9/19/14 at 5:00 PM.</p> <p>CREDITABLE ALLEGATION OF COMPLIANCE</p> <p>F157-MD Notification</p> <ul style="list-style-type: none"> Resident #1 was observed on 9/12/14 at approximately 6:30am by NA with flushed skin and blood coming from resident ears. NA notified nurse of resident flushed skin and blood coming from resident #1 ears on 9/12/14. Nurse assessed resident #1 at approximately 6:45 am on 9/12/14 with O2 sats range at 92% and skin color slightly purple. Nurse applied O2 and sats went to 97%, blood pressure 134/58 and heart rate 98. Resident #1 was reassessed on 9/12/14 at approximately 7:00 am by the third shift and first shift nurse with no active bleeding noted. First shift nurse continued to assess resident #1 on 9/12/14 at 8:30 am with no active bleeding observed. First shift nurse reassessed resident #1 on 9/12/14 around 9:30 am and observed a rash on resident face and light discoloration to resident face. On 9/12/14 9:30am the MD (physician) office nurse was made aware by first shift nurse of bleeding from resident #1 ears at 6:30am, rash on face, and light discoloration to resident face. Resident #1 was assessed by first shift nurse again at approximately 10:30 am an observed darkening under resident ' s eyes. On 9/12/14 first shift nurse contacted MD office nurse again and notified of darkening under resident ' s eyes. Order received from MD office nurse on 9/12/14 approximately at 11:48am MD order was written to send resident to ER. Hall nurse assigned to resident #1 during the acute change was drug tested and suspended by the 	F 157			

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F 157	Continued From page 13 Administrator on 9/15/14. NA assigned to resident #1 during the acute change in condition was suspended and drug tested by the Administrator on 9/16/14. An inservice was initiated on 9/12/14 and an additional inservice was initiated on 9/16/14 with both in-services completed at 100% by 9/18/14 with all other licensed nurses by the Staff Facilitator (Staff Educator) regarding assessing acute changes in condition, sending resident out if unable to contact MD, examples of acute changes to include abnormal bleeding, notification to physician by telephone when an acute change in condition to include cognitive status, behavior, immune system response, normal body system functioning, changes in cognitive status, changes in behavior, changes in oral intake to include fluids, changes in immune system, changes in normal body functioning, Panic laboratory values, resident ' s condition warrants based upon nurse ' s assessment; If you are unable to reach Attending Physician, you may call On-call for physician; If you are unable to reach attending or on-call physician, you may call the facility ' s Medical Director. Notification of the physician of these types of changes in a resident ' s condition by fax is not acceptable. Handouts given to staff for reference. No nurse will be allowed to work without first receiving the in-services. · Acute Change is defined as anything outside the norm for a resident to include but not limited to abnormal bleeding, skin color changes, changes in behaviors, change in mental alertness and orientation, increased weakness or fatigue, change in abilities to feed, bathe, or groom self, change is sitting balance, transfer, or walk, change in appetite, change in ability to chew/swallow food, difficulty with breathing, complaints of dizziness, change in bowel	F 157			

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F 157	<p>Continued From page 14</p> <p>elimination habits, complaints of nausea and vomiting, and falls.</p> <ul style="list-style-type: none"> 100% of all current residents were physically observed for acute changes in condition to include changes in skin color and bleeding on 9/15/14 by DON Director of Nurses), Staff Facilitator , QI (Quality Improvement) nurse, MDS (Minimum Data Set) nurses (2) and facility consultant. Four concerns were noted during this audit and corrected by the treatment nurse on 9/15/14 and 9/16/14 with interventions placed, MD and RP (resident representative) notification, and documentation in the progress notes. Three months of nurse ' s notes were reviewed to ensure all documented acute changes in condition to include changes in skin color and bleeding have been addressed with appropriate interventions placed, Attending Physician notification and Responsible Party notification of the acute change on 9/15/14 by DON, Staff Facilitator nurse, QI nurse, MDS nurses (2) and facility consultant. Two concerns were noted during this audit with reassessment of the resident by the treatment nurse on 9/16/14, no concerns observed during the reassessment, and documentation in the progress note. An inservice was initiated with 100% of license nurses to include agency nurses initiated on 9/12/14, on assessment of acute changes in condition, sending resident out if unable to notify MD, notification to physician by telephone to include second shift, third shift and weekends; when an acute changes in condition occur, including abnormal bleeding, changes in cognitive status, behavior, oral changes to include fluids, immune system response, normal body system functioning, Panic laboratory values, resident ' s condition warrants based upon nurse ' s assessment; If you are unable to reach Attending 	F 157			

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F 157	Continued From page 15 Physician, you may call On-call for physician; If you are unable to reach attending or on-call physician, you may call the facility ' s Medical Director. Notification of the physician of these types of changes in a resident ' s condition by fax is not acceptable. This in-service was 100% completed on 9/18/14 by Staff Facilitator. In-service on 9/18/14 was initiated by Staff Facilitator regarding Notifying the MD through the hospital after office hours and location of after-hours numbers. No license nurse will be allowed to work until receiving the in-service on MD after-hours notification. All newly hired licensed nurses and newly assigned agency staff will be in-serviced in orientation on notification to the physician of acute changes in resident condition and the after-hours notification of MD. · The staff nurse is responsible to assess, document, provide appropriate interventions and notify Attending Physician and Responsible Party of any acute changes in condition noted. On 9/18/14 the after-hours MD notification number was posted at each nurse ' s station by the DON. If the staff nurse is unable to reach the attending physician, the on-call MD must be called. If unable to contact the attending or the on-call MD, the nurse must call the Medical Director. The staff nurse will implement appropriate interventions based on the needs of the resident and notify Attending Physician and Responsible Party. Staff will notify the DON or on-call nurse of any acute changes. DON, QI nurse, Staff facilitator and MDS nurses were in-serviced by the Administrator on 9/16/14 concerning when they are on-call and they receive a call concerning a change in condition of a resident that they are to ask more questions, if needed, to get a clear picture of what is occurring with the resident and to insure that the nurse has notified the MD of the	F 157			

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F 157	Continued From page 16 acute change. On 09/19/2014 at 7:10 PM the credible allegation was validated and Immediate Jeopardy was abated at 7:35 PM when interviews with nursing staff revealed awareness of emergent changes in condition. Staff verified training had been received, that changes in condition were to be documented in the medical record, an RN was to be involved in the assessment, the physician should be notified and the resident transferred for acute care as indicated. Interviews revealed that if the attending or on-call physician could not be reached, the facility's Medical Director should be called. The number for paging the physicians after regular business hours was posted at the nursing station.	F 157			
F 223 SS=J	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews, interview with Department of Social Services, Physician interviews and interview with the police Detective, the facility failed to ensure 1 of 4 residents reviewed for abuse was free from a combination of injuries determined to be life-threatening, not self-inflicted nor the result of	F 223	F223-ABUSE Resident #1 was observed on 9/12/14 at approximately 6:30am by CNA with flushed skin and blood coming from resident ears. CNA notified nurse of	10/20/14	

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F 223	<p>Continued From page 17</p> <p>a fall. Resident #1 was admitted to the emergency room with bruising on her face, neck and arm, had a petechial rash on her face, swelling in her face and neck, blood in her ears and was showing signs of neck pain. Immediate jeopardy began on 09/12/2014 when the resident was found to have a purple face, blue lips, bleeding out of both ears and a bruise on her face and under her eyes. Immediate Jeopardy was removed on 09/19/2014 at 7:35 PM. The facility remained out of compliance at a lower scope and severity of (D) isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility completes the staff training required. The facility was in the process of monitoring the implementation of their corrective action. The findings included:</p> <p>Resident #1 was admitted to the facility on 04/18/2012 from an acute care hospital. Her cumulative diagnoses included multiple contractures, muscle weakness, anoxic brain damage, depression, cerebral artery occlusion with infarct, and asthma.</p> <p>The most recent Minimum Data Set (MDS) dated 6/19/14, indicated the resident had long and short term memory problems and decision making ability was severely cognitively impaired. The MDS indicated the resident was rarely or never understood, required total assistance for bed mobility, had contractures in both lower extremities and could not ambulate. Per the MDS, the staff assessment of the resident's mood did not indicate the presence of any symptoms of depression, mood disorder or behaviors.</p> <p>Resident#1's Plan of Care, most recently updated on 7/21/2014, indicated the resident had feelings</p>	F 223	<p>resident flushed skin and blood coming from resident #1 ears on 9/12/14. Nurse assessed resident #1 at approximately 6:45 am on 9/12/14 with O2 sats range at 92% and skin color slightly purple. Nurse applied O2 and sats went to 97%, blood pressure 134/58 and heart rate 98. Resident #1 was reassessed on 9/12/14 at approximately 7:00 am by the third shift and first shift nurse with no active bleeding noted. First shift nurse continued to assess resident #1 on 9/12/14 at 8:30 am with no active bleeding observed. First shift nurse reassessed resident #1 on 9/12/14 around 9:30 am and observed a rash on resident face and light discoloration to resident face. On 9/12/14 the MD office nurse was made aware by first shift nurse of bleeding from resident #1 ears at 6:30am, rash on face, and light discoloration to resident face. Resident #1 was assessed by first shift nurse again at approximately 10:30 am an observed darkening under resident's eyes. On 9/12/14 first shift nurse contacted MD office nurse again and notified of darkening under resident's eyes. Order received from MD office nurse on 9/12/14 approximately 11:00 am to send resident to ER. Hall nurse assigned to resident #1 during the acute change was suspended and drug tested by the Administrator on 9/15/14. CNA assigned to resident #1 during the acute change in condition was suspended and drug tested by the Administrator on 9/16/14. On 9-15-14 APS worker reported to facility that hospital made allegation that resident #1 had been strangled. Resident #1 was already in the</p>		

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F 223	<p>Continued From page 18 of depression and ineffective coping characterized by tearfulness, anxiety and repetitive motor agitation.</p> <p>Documentation in Resident #1's record was reviewed for the events on 09/12/2014. An entry dated 09/12/2014 at 12:15 AM, indicated the resident was in bed with her eyes closed, that she was incontinent and required staff turning and repositioning. The entry stated there were no acute changes or signs of distress. The note was signed by LPN#1.</p> <p>The next entry was dated 09/12/2014 at 6:51 AM and read, "CNA (Nursing Assistant) informed me that resident was bleeding out of her ears. Resident had blood coming out of her ears and her face was slightly purple." The note also stated the Resident's oxygen saturation level (O2 sat) was 92%. After the resident was given oxygen the O2 sat was 97%, the blood pressure was 134/58 and heart rate was 98. The note indicated the Director of Nursing (DON) was informed, a voicemail message had been left for the attending physician and the nurse was unable to contact the responsible party (RP). The note was signed by Licensed Practical Nurse (LPN)#1.</p> <p>A physician's telephone order, dated 9/12/2014 at 11:48 AM stated Resident #1 was to be sent to the hospital emergency room for evaluation.</p> <p>At 12:05 PM on 09/12/2014 the progress note read, "Resident being assessed throughout the shift. No Bleeding noted thus far, but a rashy area to upper face and dark circles to Bilat (both) eyes noted. Resident continues on 2L (2 liters) O2 via NC (nasal cannula). Resident grimacing more than usual. MD (physician) made aware. No</p>	F 223	<p>hospital during the time of the allegation. Hospital reported allegation of strangulation to the local law enforcement which came to the facility to investigate on 9/15/14. 24 hour report for allegation of abuse/suspicion of crime was completed and faxed to the NC Health Care Personnel Registry 9-16-14 by the Administrator. The investigation of the injury of unknown origin and abuse was initiated by the Administrator on 9/15/14 and completed on 9/18/14. The 5 day report was completed and faxed to the NCHCPR on 9/18/14.</p> <p>The facility Admission Coordinator initiated abuse interviews for all alert and oriented residents. There were 29 alert and oriented residents interviewed with questions regarding: Do they feel safe in the facility? Has anyone come into their room, visitor or another resident that made them feel uncomfortable? Has anyone physically or verbally harmed them? On 9-15-2014. Additional interviews were conducted on 9/18/14, 9/20/14, 9/21/14, 9/22/14, 9/23/14 and 9/24/14. No concerns voiced by residents interviewed. All other residents who are unable to communicate or who are disoriented were assessed by DON, QI nurse, MDS nurses, and staff facilitator for any bodily signs of abuse on 9/15/14. No bodily signs of abuse or injury of unknown origin. An additional skin assessment on all current residents was conducted on 9/22/14 by the DON, QI nurse, Staff Facilitator, and the MDS nurses. No</p>		

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F 223	<p>Continued From page 19 answer at RP's number. DON made aware." This note was signed by LPN#2.</p> <p>A progress note dated 09/12/2014 at 12:15 PM read, "Resident being assessed throughout the shift. No bleeding noted thus far, but a rashy area to upper face and dark circles to Bilat eyes noted. Upon starting shift no black circle noted. Area around eyes appeared to slowly darken throughout the shift. Resident continues on 2L O2 via NC. Resident grimacing more than usual. MD made aware. No answer at RP's number. DON made aware." The note was signed by LPN#2</p> <p>Review of an ambulance transportation "Patient Care Report" included, "Chief Complaint: Abdominal Pain. Primary Symptom: Pain. Patient found in bed in nursing home, pt (patient) was observed to be guarding her abdomen and had two black eyes, nurse stated she did not know how she got the black eyes and that they were not black yesterday." The transport note indicated on 09/12/2014 at 12:28 PM they departed from the nursing home and arrived at the hospital at 12:31 PM.</p> <p>The hospital Emergency Department exam report dated 09/12/2014 included, "Patient with petecchiae to face and ecchymosis around eyes, blood from ears. There are bruises along the patient's throat that are suspicious for finger prints. I am concerned about elder abuse and attempted strangulation. Will notify DSS (Department of Social Services) and plan to admit patient for her safety until this situation can be investigated. Pt (patient) is nonverbal but when I ask her if anyone hurt her, her eyes began to tear up." The report was signed by Hospital Physician #1.</p>	F 223	<p>concerns were noted.</p> <p>The procedure for all allegations of abuse and injury of unknown origin is as follows: Any employee accused of abuse will be immediately removed from resident care area to an office. The resident will be assessed by a license nurse and will document in the medical record. Corrective measures will be initiated immediately to protect the resident. Statements will be obtained from identified employee, if any, and any possible witnesses. Employee will be suspended immediately per policy pending outcome of investigation. The Administrator and/or DON will complete and send to RVP for prior approval and then fax the 24 hour report to the NCHCPR. Notification of law enforcement if applicable. Resident interviews will be conducted by the Admissions Coordinator with alert and oriented residents and physical assessments will be conducted for non-alert and oriented residents by license nurse. At the completion of the investigation the Administrator and/or the DON will submit a 5 day report to the NCHCPR. The Administrator is responsible to direct the investigation process and to ensure that the appropriate agencies, to include the NCHCPR, are notified per policy.</p> <p>An Action Checklist was initiated on 9/19/14 for License nursing staff and placed at each nurse's station for licensed nurses to complete for all</p>		

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F 223	<p>Continued From page 20</p> <p>The Radiology report (dated 09/12/2014) revealed the Computerized Tomography (CT) scan was negative for a cranial fracture, there was no mass or hematoma and no other significant findings.</p> <p>During an interview on 09/19/2014 at 9:51 AM, Hospital Physician #1 discussed her findings regarding her examination of Resident #1 on the afternoon of 09/12/2014. Hospital Physician #1 said that in addition to the bruising around her eyes and on her neck, Resident #1 also had a bruise on her upper arm when she came into the emergency department (ED). Hospital Physician #1 said, "We had to call the nursing home three times to get the list of medications." and added that Resident #1 wasn't on any medications that would have caused the petechiae or bruising. Hospital Physician #1 said, "Very few things will cause that petechial rash. It is forensically distinctive,- pathognomonic [specifically characteristic of a disease or condition; denoting a sign or symptom on which a diagnosis can be made]." The physician further stated, "The petechial rash is indicative of strangulation or a crushing force. I could not find anything else that would have caused it with this patient."</p> <p>The documentation from Resident #1's admitting hospital physician (Hospital Physician #2) dated 09/12/2014 included, "Her face appears atraumatic except for large periorbital, infraorbital ecchymosis (bruising under and around the eyes).Patient has a petechial rash from the upper lip up to the forehead." The document also indicated there was a little bit of petechial rash "on the left side of the neck." Hospital Physician #2's assessment included, "Petechial rash. Is it a</p>	F 223	<p>allegations of abuse and injury of unknown origin. The Action Checklist includes:</p> <ul style="list-style-type: none"> " Remover involved employee, if known, from resident care area to an office: instruct employee to wait in office until your return " Notify Administrator and/or DON immediately of incident " Assess resident: document notification in chart " Notify attending MD; document notification in chart " Implement MD orders as indicated " Notify resident's representative as indicated; document notification in chart " Obtain employee witness statement of incident " Drug test employee per personnel policy as applicable or as instructed by Administrator or DON " Punch employee out and send home immediately pending outcome of investigation " Implement corrective measures to protect resident (i.e., alarm bracelet, padding of equipment, 1:1 monitoring, etc.) " Completion of Resident QI Reporting form (electronic QI incident record) " Continue to monitor resident as appropriate <p>All license nurses to include LPN #1, LPN #2, LPN #3, and LPN #4 were in-serviced on the Action Checklist that has been placed at all nurses' station, initiated 9/19/14 by the Staff facilitator and was completed 100% on 9/23/14.</p>		

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F 223	<p>Continued From page 21</p> <p>case of elderly abuse? We spoke with the nursing home staff and they truly do not have any idea of what happened. Patient is not ambulatory. She is totally bedridden so there was no history of a fall. This has to be investigated and DSS will be called."</p> <p>Hospital Physician #2 was interviewed on 09/18/2014 at 10:44 AM and said, "This patient has so many unexplained injuries. These were life-threatening injuries." When asked about possible causes for the bleeding from the ears, Hospital Physician #2 stated that bleeding from the ears was usually associated with a skull fracture or very forceful coughing. She further stated that petechiae is often found with strangulation or forceful vomiting and that the nursing home had said there was no vomiting. Hospital Physician #2 said that tests showed no cranial fracture but there was swelling of the soft tissue in her face and neck, bruising, and subconjunctival hemorrhaging. Hospital Physician #2 said, "I don't know of anything that could cause all of that other than strangulation when you rule out a fall, vomiting or forceful cough." Physician #2 indicated that during communication with the facility she had only asked questions and had not shared any concerns with facility staff. Hospital Physician #2 indicated Resident #1 was still in the hospital.</p> <p>On 9/17/2014 at 5:05 PM, the Department of Social Services (DSS) Social Worker stated the hospital had called their hotline and left a message after hours on Friday, 9/12/2014, with allegations of abuse and strangulation. The Social Worker also said this resident "didn't have much family contact."</p>	F 223	<p>" The staff nurse is responsible to assess, document, provide appropriate interventions and notify Attending Physician and Responsible Party of any acute changes in condition noted. On 9/18/14 the after-hours MD notification number was posted at each nurse's station by the DON. If the staff nurse is unable to reach the attending physician, the on-call MD must be called. If unable to contact the attending or the on-call MD, the nurse must call the Medical Director. The staff nurse will implement appropriate interventions based on the needs of the resident and notify Attending Physician and Responsible Party. Staff will notify the DON or on-call nurse of any acute changes. DON, QI nurse, Staff facilitator and MDS nurses were in-serviced by the Administrator on 9/16/14 concerning when they are on-call and they receive a call concerning a change in condition of a resident that they are to ask more questions, if needed, to get a clear picture of what is occurring with the resident and to insure that the nurse has notified the MD of the acute change.</p> <p>The DON will determine if the acute change in condition reported by the hall nurse fits the definition of an injury of unknown origin-Injury of any type that occurs where the cause or contributing factor is not known or determined. If the acute change in condition fits the definition of an injury of unknown origin then the abuse/injury of unknown origin procedure will be followed to include: Any employee accused of abuse will be</p>		

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F 223	<p>Continued From page 22</p> <p>On 9/18/2014 at 11:47 AM, the Police Detective stated she was notified by the hospital on Monday 9/15/2014, about the allegation of strangulation.</p> <p>The facility provided their investigation and written statements from the facility staff taken on 09/15/2014 through 09/17/2014. After review of each written statement, the facility staff were interviewed during the survey.</p> <p>On 09/16/2014 Nursing Assistant (NA) #1 wrote, "(Resident #1) had no falls on 11-7 that I'm aware of in the last 2 wks (weeks)." An interview was conducted with NA #1 on 09/18/2014 at 10:42 AM. NA#1 indicated she was working the 11 PM to 7 AM shift, had provided care for Resident #1, and was the person who discovered Resident #1 with bleeding ears. NA#1 stated that the resident required total care and when agitated, would pull off her nightgown and incontinent brief. NA #1 stated during that night the resident had been agitated and ripping her brief. At approximately 6:40 AM, NA #1 looked in to check on the resident and found her with the gown pulled up over her face. NA#1 said Resident #1 was facing the door, laying on her right side and her sheet was on the floor. NA#1 saw blood on sheet, and spots of blood, close together on the pillow in front of her face. "I had no idea where the blood was coming from, so I went to look." NA #1 turned the resident on her back, "and the blood poured out of her (left) ear" so she turned her on her back and went to look for the nurse. NA#1 reported that neither of the nurses were available but the NA from the 100 hall was doing care and she motioned for her to come with her to Resident #1's room. NA#1 and NA#2 went back to the room and when NA#2 saw the resident she left to go get LPN#1. NA#1 stated that when she</p>	F 223	<p>immediately removed from resident care area to an office. The resident will be assessed by a license nurse and will document in the medical record. Corrective measures will be initiated immediately to protect the resident. Statements will be obtained from identified employee, if any, and any possible witnesses. Employee will be suspended immediately per policy pending outcome of investigation. The Administrator and/or DON will complete and send to RVP for prior approval and then fax the 24 hour report to the NCHCPR. Notification of law enforcement if applicable. Resident interviews will be conducted by the Admissions Coordinator with alert and oriented residents and physical assessments will be conducted for non-alert and oriented residents by license nurse. At the completion of the investigation the Administrator and/or the DON will submit a 5 day report to the NCHCPR. The Administrator is responsible to direct the investigation process and to ensure that the appropriate agencies, to include the NCHCPR, are notified per policy.</p> <p>The Staff Facilitator initiated in servicing for all staff on 9/15/14 to include dietary, laundry, housekeeping, AR book keeper, payroll, medical records, maintenance, activities, therapy, admission coordinator, CNAs to include NA #1 and NA #2, and license nurses LPN #1, LPN #2, LPN #3, and LPN #4 on abuse and was completed</p>		

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F 223	<p>Continued From page 23</p> <p>started to clean Resident #1 up and turned her over blood came out of the other ear. NA#1 said, "The nurse sometimes has to give her medication to get her to calm. But not that night, she was up all night long, restless." NA#1 said that she had not reported the resident's restlessness to the nurse.</p> <p>Nursing Assistant (NA) #2's undated statement included, "I got done caring for my residence(sic) and as I was making my way to the back nurses station I bumped into (NA#1) who said (Resident #1) was bleeding. As I enter the room I noticed that her face was blue and that their (sic) was blood in her ears." NA#2's statement included that the resident was scratching her face. NA#2 left to find nurse #1 who told her to get the resident's vital signs. NA#2 was interviewed during the survey, on 9/18/2014 at 5:20 PM and said, "I was through with my rounds and saw (NA#2) was coming out of her room and she said (Resident #1) was bleeding and she didn't know why or where. So I followed into the room and her (Resident #1's) face was blue and we noticed her bleeding." NA#2 said, "I left to go find a nurse and she told me to get her vitals."</p> <p>On 09/15/2014 LPN#1 wrote, "Between the times of 6:30-6:45ish am, CNA came an told me that (Resident #1) had blood coming out of her ear and was slightly purple in her face. I ran to the room with my vital sign equipment. Her pulse was high and her O2 was in the low 90s after getting oxygen put on her at 2L resident's vitals were re-taken and after were good within normal limits." LPN#1 was interviewed during the survey, on 09/18/2014 at 11:14 AM, and said she had given the resident her scheduled medications (Synthroid and Prilosec) around 6AM and had not</p>	F 223	<p>100% on 9/17/14. The abuse inservice included that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown origins are reported as soon as possible to the Administrator, any employee who witnesses abuse or suspects abuse, must report immediately report the alleged abuse to his/her supervisor, who will then report the incident to the Administrator and/or DON, failure to report any concern related to abuse will result in disciplinary action and possible termination of employment, facility will provide supervision to staff to identify behaviors to include, but not limited to, using derogatory language, rough handling, or not communicating with residents while giving care, and employees accused of being directly involved in allegations of abuse or neglect while be suspended immediately from employment pending the outcome of the investigation. All staff, to include housekeeping, laundry, dietary, maintenance, AR book keeper, receptionist, payroll, medical records, activities, therapy, admissions coordinator, CNA's and license nurses was in-serviced Burnout to include definition and signs and symptoms, ways to prevent and what to do if you observe a co-worker with Burnout, was initiated 9/18/14 by Staff Facilitator and this was completed on 9/27/14.</p> <p>Upon hire all newly hired employees will review and receive the abuse policy and procedures in-service and validation abuse quiz prior to taking an assignment</p>		

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F 223	<p>Continued From page 24</p> <p>noticed any agitation at that time or earlier in the night. LPN#1 stated that the resident had not had problems during the night and no one had reported any fall or agitation with regard to Resident #1. When asked how she had learned of the resident's condition that morning LPN#1 said, "(NA#2) reported it to me. She said (Resident #1) was slightly purple in her face and she had blood coming out of her ear. I think it was her left ear. I got vital signs right away. She had blood coming out of her ear and she was purple in her face like she wasn't getting enough oxygen." When asked about the amount of blood coming from the resident's ears LPN#1 replied, "I would say it was like a nose bleed. It wasn't gushing but was actively flowing." LPN#1 stated that she called LPN#2 and #3. She indicated LPN #2 went to get the oxygen and the resident's oxygen saturation level "started to come up and color started to come back and the bleeding had stopped." LPN#1 stated there were no other residents in the hallways and when asked what she thought had occurred she stated, "I have no idea." LPN#2 said, "I called the DON and I told her everything that was going on, - the blood, purple and O2 and that her vital signs were okay. I called the doctor and left a message. The next nurse came on and I told her everything." When asked about what might cause bleeding from both ears, LPN#1 said, "I don't know."</p> <p>On 09/15/2014 LPN#2's statement included that LPN#1 had called for assistance and when she entered the resident's room the NAs were changing the bed. "The ring of blood I saw was approximately four inches in diameter. (LPN#1) stated that resident was bleeding from her ears. Resident's lips were bluish tinged so I told</p>	F 223	<p>during orientation by the Staff Facilitator. All potential employees will be screened by the facility for abuse by the Staff Facilitator prior to employment. This screening process will include the requesting of information from previous and/or current employers i.e. reference checks, checking with the appropriate license board and/or registries, and completion of criminal background check. Any employee found to have an allegation of abuse against them will not be offered employment.</p> <p>Abuse quizzes were initiated on 9/17/14 with all staff to include dietary, laundry, housekeeping, AR book keeper, payroll, medical records, maintenance, activities, therapy, admission coordinator, CNAs to include NA #1 and NA #2, and license nurses LPN #1, LPN #2, LPN #3, and LPN #4 by the Staff facilitator to validate staff knowledge of abuse and was completed by 100% of staff on 9/22/14. These questions include; who should you report abuse to? When should you report abuse? Give 2 examples of abuse? What is the first thing you do if you see or hear a resident being abused from a staff member or visitor? 100% validation was completed with all staff. Any staff member unable to answer any questions accurately on the quiz will be immediately re-trained and tested again by the Staff Facilitator. Staff who are unable to correctly answer the questions on the quiz after two attempts will be removed from working with residents until they are able</p>		

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F 223	<p>Continued From page 25</p> <p>(LPN#1) I would get oxygen." The statement indicated that LPN#2 told LPN#1 to call Resident #1's attending physician. LPN#2 was interviewed on 9/19/14 at 3:50 PM. LPN#2 said, "I did see blood, probably the size of a grapefruit, maybe 3-4 inches on the sheet or pillowcase. The resident's lips were a little blue tinged so I went to get some oxygen." LPN#2 stated she herself did not do an assessment of Resident#1 and that LPN#1 applied the oxygen and took vital signs. When asked about what might cause bleeding from both ears LPN#2 said, "When (LPN#1) told me she couldn't get the doctor- that he didn't answer, I told her to call the DON." When asked if she told LPN #1 to call the hospital to contact the physician outside regular office hours, LPN#2 indicated she only told her to call the doctor and added "I can't tell you that I did tell her or that I didn't tell her on any prior occasion."</p> <p>LPN #3 provided a written statement for the facility on 09/17/2014. The statement included that when LPN#3 arrived at the 200 hall nursing station, LPN#1 told her that everything was okay. LPN#3 went into Resident #1's room and saw blood in her ear and on the pillowcase. LPN#3 was interviewed during the survey on 09/19/2014 at 4:15 PM. LPN#3 said that on the morning of 09/12/2014 she had been giving report when someone paged for all nurses to go to the 200 hall. "She (LPN#1) didn't call any kind of a code or anything so we just walked there." LPN#3 said that when she arrived at the nursing station, "(LPN#2) said 'That's okay, we got it.'" LPN#3 stated she went to Resident #1's room and saw blood in the resident's right ear. LPN## stated she did not do an assessment of the resident but did ask the NAs in the room what happened, "and they all said they didn't know." LPN#3 said</p>	F 223	<p>to validate knowledge. Staff members unable to validate knowledge will not be allowed to work in this facility. The Staff Facilitator will continue abuse in-services for all staff monthly for four months and all new orientees hired will receive this training before working with residents.</p> <p>Staff to resident interactions were initiated on 9/17/14 by Facility Consultant observing how staff to include housekeeping, therapy, dietary, nursing to include NA #1, NA #2, LPN #1, LPN #2, LPN #3, and LPN #4 , interact with the residents and for sign and symptom of abuse. These staff to resident interaction were completed with 100% of all employees, on all shifts, to insure appropriate interaction with the resident on 9/27/14. The abuse policy will be initiated for any employee found to be inappropriate with a resident to include, but not limited to, removal of the employee from the resident, suspension, investigation, notification to the appropriate State agency, disciplinary action up to termination.</p> <p>The Administrator coordinated with the Sheriff Department and the City Police to provide off duty police officer will provide 3rd shift monitoring in facility for suspicious activity from 9/23/14 to 10/07/2014. A schedule for department managers, Dietary manger, dietary assistant manager, activity director, assistant activity director, payroll, supply clerk, medical records, Administrator,</p>		

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F 223	<p>Continued From page 26</p> <p>she observed fresh blood, "about the size of a donut" on the linen and the resident was grimacing. She said, "I didn't know what to think" and added "I would have called the doctor and then called the DON and if the doctor didn't call back then I would have called the DON again."</p> <p>On 09/15/2014 the DON wrote that on 09/12/2014 at approximately 6:50 AM, "I received a call from (LPN#1). She stated that (Resident #1) had some blood coming out of her ears and she didn't know what to do. I said you need to call the doctor and make sure to call the R.P. (Responsible Party) as well. She stated okay. I got to the facility (approximately) 8:30 on 9/12/14 and I had not heard anything else regarding resident status until 7-3 nurse (LPN#4) stated that she had sent the resident to the ER for rash on face and dark circles forming under eyes." The DON was interviewed during the survey on 09/18/2014 at 5:35 PM and said, "I got a phone call from (LPN#1) at about 6:45-6:50. She said (Resident #1) had blood from her ear and she didn't know what to do. I told her she needed to call the doctor and report it." The DON stated that she did not inquire further about the blood from the resident's ears and said, "I thought it was a skin tear or scratch or something. I didn't think it was anything emergent but I did tell her to call the doctor." The DON added, "I should have been more inquisitive." The DON said she spoke to the day shift nurse (LPN#4) and learned that the bleeding from the ears had stopped but the DON did not go to the room to assess the resident herself. The DON stated that a lot of blood from a resident's ears could be a sign of a head injury and said, "I would have expected her (LPN#1) to send her to the hospital when they saw the amount of blood I have since learned of."</p>	F 223	<p>DON, QI nurse, Staff facilitator and MDS nurses (2) to observe residents after the hours of 5pm to include 3rd shift was initiated 9/19/14, 7 days per week to include nights and week-ends. The department managers will use a checklist and observe all residents for: Does the resident seem fearful (flinching, guarding, tearful)? Are there any visible bruising, edema, red areas to include the face and neck? Staff interactions with residents for signs and symptoms of abuse. If noted to be any concerns during the observations, Dietary manger, dietary assistant manager, activity director, assistant activity director, payroll, supply clerk, medical records, Administrator, DON, QI nurse, Staff facilitator or MDS nurses (2) will immediately contact the hall nurse and the Administrator.</p> <p>Resident abuse interviews will be conducted by the Admissions Coordinator and/or Social Worker with questions regarding residents understanding of abuse and if this has occurred to the resident. These interviews will occur weekly X☐s 4 weeks, then monthly X☐s 3 months utilizing a QI tool. Current residents will be physically observed for any bodily injury of abuse or any of unknown injury using census as documentation, Monday-Friday X☐s 4 weeks, then weekly X☐s 4 weeks and then monthly X☐s 3 months and any concerns immediately reported to the Administrator and DON to insure all identified abuse allegations and Injury of unknown origin were thoroughly</p>		

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F 223	<p>Continued From page 27</p> <p>The DON said if the nurse did not hear back from the physician that the resident should have been sent to the hospital for evaluation. The DON said she learned that LPN#1 had called the physician's office and left a message on the answering machine. Upon request the DON reviewed the physician numbers posted at the nursing station and said the off-hours paging number for that doctor was not posted at the desk. The DON also indicated that none of the Registered Nurses in the building on that Friday morning of 09/12/2014, had assessed Resident #1.</p> <p>LPN#4's undated statement indicated she was told by the off-going nurse that Resident #1 had been bleeding from her ears. "The nurse mentioned to another that it was a lot. She attempted to get in touch with the resident's doctor but never talked to him." LPN#4's statement also included, "All the while in the back of my mind I'm thinking her doctor was paged at some point and he should be calling soon." The statement indicated LPN#4 had checked the resident at approximately 8:30 AM and there was no active bleeding from the ears and no other symptoms but about an hour later the resident had developed a rash around her eyes and there was some discoloration on her face. "I then called the MD's (physician's) office to see why they hadn't called and to tell them about the rash. I spoke with the MD's nurse and told her about the bleeding from the previous shift as well. She stated she would let him know and call back. Not even an hour later resident began to have dark circles under her eyes like blood had pooled there. I called the MD's office back to let them know and found out from the nurse that the MD said that he never received any pages or</p>	F 223	<p>investigated per policy and submitted to the NCHCPR. This will be completed by DON, QI nurse, staff facilitator, and/or MDS nurses. The Administrator will review the resident abuse interviews and physical assessment weekly X☐s 4 weeks, then monthly X☐s 3 months for completion and any concerns.</p> <p>Abuse quizzes to be completed by all facility staff to include housekeeping, therapy, dietary, nursing to include NA #1, NA #2, LPN #1, LPN #2, LPN #3, and LPN #4 to ensure staff knowledge on the policy and procedure of abuse, will occur for all staff daily with 10 interviews on 7-3 shift, 6 interviews on 3-11 shift and 4 interviews on 11-7 shift weekly X☐s 4 weeks and then monthly X☐s 3 months utilizing a QI tool. The Administrator will review the abuse quizzes weekly X☐s 4 weeks, then monthly X☐s 3 months for completion and any concerns. Staff interactions will occur daily will all facility staff on all 3 shifts to include NA #1, NA #2, LPN #1, LPN #2, LPN #3, and LPN #4, 10 interactions on 7-3 shift, 6 interactions on 3-11 shift, 4 interactions on 11-7 shift, X☐s 4 weeks, then weekly X☐s 4 weeks, then monthly X☐s 3 months utilizing a QI tool to document the staff to resident interactions. The Administrator will review the staff interactions weekly X☐s 4 weeks, then monthly X☐s 3 months for completion and any concerns. Off duty police officer will monitor facility on 3rd shift for suspicious activity X 2 weeks utilizing a QI tool. The Administrator will review the off duty</p>		

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F 223	<p>Continued From page 28</p> <p>calls from anyone about the matter. I was instructed to send the resident out to the hospital for evaluation. Resident was alert with eyes open when she left. I was asked by MD's office if resident has sustained any falls but I was unaware of any recent falls." LPN#4 was interviewed during the survey on 09/18/2014 at 10:08 AM. She stated when she examined Resident #1 she didn't see any blood but there was a light purple discoloration on the right side of her face and the discoloration was on her forehead too. "I was waiting for the doctor to call back and I continued with my med-pass." LPN#4 stated that about one and a half hours later she checked the resident and the oxygen was still on at 2L per minute. She said the treatment nurse went in to change a dressing and identified the rash on the resident's face as petechiae. LPN#4 said she called the attending physician's nurse and then about an hour and a half later she noted the dark circles forming under her eyes and called the physician's office again. The resident went out to the hospital at approximately noon. LPN#4 said, "I thought she had fallen when her eyes started to turn black but night shift said she had not fallen and she was in bed all day for us and I know she didn't have a fall. I was thinking closed head injury or that she had fallen." She added, "I called the DON to tell her I was sending (Resident #1) out."</p> <p>During an interview on 09/18/2014 at 6:38 PM, the Administrator was asked about when she was informed by staff about Resident #1's condition. The Administrator said, "I was informed at the time (Resident #1) was going out (to the hospital). I was told she had rash on her face that developed throughout the morning and she was starting to get some discoloration under her eyes.</p>	F 223	<p>police officer round sheets weekly X□s 2 weeks.</p> <p>Department managers will observe resident after the hours of 5pm, to include 3rd shift per schedule utilizing a QI tool to document observation daily X□s 4 weeks, then weekly X□s 4 weeks, then monthly X□s 3 months. The Administrator will review the department managers after hours observations weekly X□s 4 weeks, then monthly X□s 3 months for completion and any concerns.</p> <p>The Executive QI committee, to include, but not limited to, the Facility Medical Director, Administrator, DON, and QI nurse will meet weekly X□s 4 and then monthly to review resident abuse interviews, audits for bodily injury, Abuse quizzes, staff to resident interactions, off duty police officer round sheets, and department managers after hours observations to determine any issues and/or trends and the need for continued monitoring and the frequency of audits.</p>		

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F 223	<p>Continued From page 29</p> <p>I was also told about the blood out of one of her ears " The Administrator also said, "My first question was if she had a recent fall or struck her head. When I was told about the rash and discoloration I thought there was an acute condition going on after ruling out a fall." She said, "My initial thought (on 09/12/2014) was not that someone harmed her but what was going on clinically. I never thought that someone hurt her." She added, "I had no reason to initiate investigation of injury of unknown origin." When asked if a Registered Nurse (RN) had assessed Resident #1 on 09/12/2014, the Administrator said, "Not to my knowledge." When asked if she would expect an RN to assess if one was available, the Administrator said, "No I would have expected the nurse to send her out. If the nurse came in and found her blue with blood coming out of her ears I would have expected her to send her out." The Administrator indicated she was informed about the allegation of abuse on Monday, 09/15/2014 and initiated an investigation at that time.</p> <p>During an interview on 09/19/2014 at 5:15 PM, the Administrator said, "I would have expected (LPN#1) to do a full assessment. I would have expected her to call 911. I would have expected (the DON) to have more discussion regarding that assessment." When asked her expectations of staff regarding injuries of unknown origin, the Administrator said, "I don ' t expect my staff to recognize an injury of unknown origin. I expect them to tell me about any suspicions about an injury so myself and (the DON) can make a determination."</p> <p>During an interview on 09/25/2014 at 9:11 AM, Resident #1's attending physician in the facility stated, "I was informed that the day nurse had</p>	F 223			

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F 223	<p>Continued From page 30</p> <p>been waiting for a call back from me but I didn't know anything about an earlier call about the bleeding from both ears earlier." The physician stated the resident was not on any medications that would cause bleeding from the ears or petechiae. The physician said, "I would expect the nurse to send her to the hospital to see why she was bleeding from the ears." He added, "This (bleeding from the ears) was definitely an emergency."</p> <p>The Administrator was notified of the Immediate Jeopardy for F309 on 9/18/14 at 7:41 PM.</p> <p>The facility provided the following credible allegation of compliance on 9/19/14 at 5:00 PM.</p> <p>CREDIBLE ALLEGATION OF COMPLIANCE</p> <p>F223-ABUSE</p> <p>Resident #1 was observed on 9/12/14 at approximately 6:30am by NA with flushed skin and blood coming from resident ears. NA notified nurse of resident flushed skin and blood coming from resident #1 ears on 9/12/14. Nurse assessed resident #1 at approximately 6:45 am on 9/12/14 with O2 sats range at 92% and skin color slightly purple. Nurse applied O2 and sats went to 97%, blood pressure 134/58 and heart rate 98. Resident #1 was reassessed on 9/12/14 at approximately 7:00 am by the third shift and first shift nurse with no active bleeding noted. First shift nurse continued to assess resident #1 on 9/12/14 at 8:30 am with no active bleeding observed. First shift nurse reassessed resident #1 on 9/12/14 around 9:30 am and observed a rash on resident face and light discoloration to resident face. On 9/12/14 the MD office nurse</p>	F 223			

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F 223	<p>Continued From page 31</p> <p>was made aware by first shift nurse of bleeding from resident #1 ears at 6:30am, rash on face, and light discoloration to resident face. Resident #1 was assessed by first shift nurse again at approximately 10:30 am an observed darkening under resident's eyes. On 9/12/14 first shift nurse contacted MD office nurse again and notified of darkening under resident's eyes. Order received from MD office nurse on 9/12/14 approximately 11:00 am to send resident to ER. Hall nurse assigned to resident #1 during the acute change was suspended and drug tested by the Administrator on 9/15/14. NA assigned to resident #1 during the acute change in condition was suspended and drug tested by the Administrator on 9/16/14. On 9-15-14 APS worker reported to facility that hospital made allegation that resident #1 had been strangled. Resident #1 was already in the hospital during the time of the allegation. Hospital reported allegation of strangulation to the local law enforcement which came to the facility to investigate on 9/15/14. 24 hour report for allegation of abuse/suspicion of crime was completed and faxed to the NC Health Care Personnel Registry (NC HCPR) 9-16-14 by the Administrator. The investigation of the injury of unknown origin and abuse was initiated by the Administrator on 9/15/14 and completed on 9/18/14. The 5 day report was completed and faxed to the NC HCPR on 9/18/14.</p> <p>The facility Admission's Coordinator initiated abuse interviews for all alert and oriented residents. There were 29 alert and oriented residents interviewed with questions regarding: Do they feel safe in the facility? Has anyone come into their room, visitor or another resident that made them feel uncomfortable? Has anyone physically or verbally harmed them? on</p>	F 223			

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F 223	<p>Continued From page 32</p> <p>9-15-2014. No concerns voiced by residents interviewed. All other residents who are unable to communicate or who are disoriented were assessed by DON, QI (Quality Improvement) nurse, MDS nurses, and staff facilitator for any bodily signs of abuse on 9/15/14. No bodily signs of abuse or injury of unknown origin. No concerns were noted.</p> <p>The procedure for all allegations of abuse and injury of unknown origin is as follows: Any employee accused of abuse will be immediately removed from resident care area to an office. The resident will be assessed by a license nurse and will document in the medical record. Corrective measures will be initiated immediately to protect the resident. Statements will be obtained from identified employee, if any, and any possible witnesses. Employee will be suspended immediately per policy pending outcome of investigation. The Administrator and/or DON will complete and send to RVP for prior approval and then fax the 24 hour report to the NCHCPR. Notification of law enforcement if applicable. Resident interviews will be conducted by the Admissions Coordinator with alert and oriented residents and physical assessments will be conducted for non-alert and oriented residents by license nurse. At the completion of the investigation the Administrator and/or the DON will submit a 5 day report to the NCHCPR. The Administrator is responsible to direct the investigation process and to ensure that the appropriate agencies, to include the NCHCPR, are notified per policy.</p> <p>An Action Checklist was initiated on 9/19/14 for Licensed nursing staff and placed at each nurse's station for licensed nurses to complete for all</p>	F 223			

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F 223	<p>Continued From page 33</p> <p>allegations of abuse and injury of unknown origin. The Action Checklist includes:</p> <ul style="list-style-type: none"> · Remove involved employee, if known, from resident care area to an office: instruct employee to wait in office until your return · Notify Administrator and/or DON immediately of incident · Assess resident: document notification in chart · Notify attending MD; document notification in chart · Implement MD orders as indicated · Notify resident's representative as indicated; document notification in chart · Obtain employee "witness" statement of incident · Drug test employee per personnel policy as applicable or as instructed by Administrator or DON · Punch employee out and send home immediately pending outcome of investigation · Implement corrective measures to protect resident (i.e., alarm bracelet, padding of equipment, 1:1 monitoring, etc.) · Completion of Resident QI Reporting form (electronic QI incident record) · Continue to monitor resident as appropriate <p>All license nurses will be in-serviced on the Action Checklist that has been placed at all nurses' station, initiated 9/19/14 by the Staff facilitator. No license nurse will be allowed to work until receiving the Action checklist in-service.</p> <ul style="list-style-type: none"> · The staff nurse is responsible to assess, document, provide appropriate interventions and notify Attending Physician and Responsible Party of any acute changes in condition noted. On 9/18/14 the after-hours MD notification number 	F 223			

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F 223	Continued From page 34 was posted at each nurse's station by the DON. If the staff nurse is unable to reach the attending physician, the on-call MD must be called. If unable to contact the attending or the on-call MD, the nurse must call the Medical Director. The staff nurse will implement appropriate interventions based on the needs of the resident and notify Attending Physician and Responsible Party. Staff will notify the DON or on-call nurse of any acute changes. DON, QI nurse, Staff facilitator and MDS nurses were in-serviced by the Administrator on 9/16/14 concerning when they are on-call and they receive a call concerning a change in condition of a resident that they are to ask more questions, if needed, to get a clear picture of what is occurring with the resident and to insure that the nurse has notified the MD of the acute change. A QI tool, Acute Change Call Log, will be used daily by the On-Call nurse and the Administrator will review weekly. The DON will determine if the acute change in condition reported by the hall nurse fits the definition of an injury of unknown origin- "Injury of any type that occurs where the cause or contributing factor is not known or determined" . If the acute change in condition fits the definition of an injury of unknown origin then the abuse/injury of unknown origin procedure will be followed to include: Any employee accused of abuse will be immediately removed from resident care area to an office. The resident will be assessed by a license nurse and will document in the medical record. Corrective measures will be initiated immediately to protect the resident. Statements will be obtained from identified employee, if any, and any possible witnesses. Employee will be suspended immediately per policy pending outcome of investigation. The Administrator and/or DON will complete and send	F 223			

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F 223	<p>Continued From page 35</p> <p>to RVP (Responsible Vice President) for prior approval and then fax the 24 hour report to the NCHCPR. Notification of law enforcement if applicable. Resident interviews will be conducted by the Admissions Coordinator with alert and oriented residents and physical assessments will be conducted for non-alert and oriented residents by license nurse. At the completion of the investigation the Administrator and/or the DON will submit a 5 day report to the NCHCPR. The Administrator is responsible to direct the investigation process and to ensure that the appropriate agencies, to include the NCHCPR, are notified per policy.</p> <p>The Staff Facilitator initiated in servicing for all staff on 9/15/14 to include dietary, laundry, housekeeping, AR book keeper, payroll, medical records, maintenance, activities, therapy, admission coordinator, NAs, and license nurses on abuse. The abuse inservice included that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown origins are reported as soon as possible to the Administrator, any employee who witnesses abuse or suspects abuse, must report immediately report the alleged abuse to his/her supervisor, who will then report the incident to the Administrator and/or DON, failure to report any concern related to abuse will result in disciplinary action and possible termination of employment, facility will provide supervision to staff to identify behaviors to include, but not limited to, using derogatory language, rough handling, or not communicating with residents while giving care, and employees accused of being directly involved in allegations of abuse or neglect while be suspended immediately from employment pending the outcome of the investigation. There</p>	F 223			

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F 223	<p>Continued From page 36</p> <p>is 1 employee on vacation that has not received the in-service that will be mailed a certified letter on 9/19/14. All staff, to include housekeeping, laundry, dietary, maintenance, AR book keeper, receptionist, payroll, medical records, activities, therapy, admissions coordinator, NA's and license nurses was in-serviced Burnout to include definition and signs and symptoms, ways to prevent and what to do if you observe a co-worker with Burnout, was initiated 9/18/14 by Staff Facilitator. No employee will be allowed to work until receiving the Burnout in-service.</p> <p>Upon hire all newly hired employees will review and receive the abuse policy and procedures in-service and validation abuse quiz prior to taking an assignment during orientation by the Staff Facilitator. All potential employees will be screened by the facility for abuse by the Staff Facilitator prior to employment. This screening process will include the requesting of information from previous and/or current employers i.e. reference checks, checking with the appropriate license board and/or registries, and completion of criminal background check. Any employee found to have an allegation of abuse against them will not be offered employment.</p> <p>Abuse quizzes were initiated on 9/17/14 by the Staff facilitator to validate staff knowledge of abuse. These questions include; who should you report abuse to? When should you report abuse? Give 2 examples of abuse? What is the first thing you do if you see or hear a resident being abused from a staff member or visitor? 100% validation will completed with all staff. Then any staff member unable to answer any questions accurately on the quiz will be immediately re-trained and tested again by the Staff</p>	F 223			

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

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F 223	<p>Continued From page 37</p> <p>Facilitator. Staff who are unable to correctly answer the questions on the quiz after two attempts will be removed from working with residents until they are able to validate knowledge. Staff members unable to validate knowledge will not be allowed to work in this facility.</p> <p>The Staff Facilitator will continue abuse in-services for all staff monthly for four months and all new orientees hired will receive this training before working with residents.</p> <p>Staff to resident interactions were initiated on 9/17/14 by Facility Consultant observing how staff to include housekeeping, therapy, dietary, nursing, interact with the residents and for sign and symptom of abuse. These staff to resident interaction will be completed with 100% of all employees, on all shifts, to insure appropriate interaction with the resident. The abuse policy will be initiated for any employee found to be inappropriate with a resident to include, but not limited to, removal of the employee from the resident, suspension, investigation, notification to the appropriate State agency, disciplinary action up to termination.</p> <p>A schedule for department managers, Dietary manger, dietary assistant manager, activity director, assistant activity director, payroll, supply clerk, medical records, Administrator, DON, QI nurse, Staff facilitator and MDS nurses (2) to observe residents after the hours of 5pm to include 3rd shift will be initiated 9/19/14, 7 days per week to include nights and week-ends. The department managers will use a checklist and observe all residents for: Does the resident seem fearful (flinching, guarding, tearful)? Are there any visible bruising, edema, red areas to include the</p>	F 223			

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F 223	Continued From page 38 face and neck? Staff interactions with residents for signs and symptoms of abuse. If noted to be any concerns during the observations, Dietary manger, dietary assistant manager, activity director, assistant activity director, payroll, supply clerk, medical records, Administrator, DON, QI nurse, Staff facilitator or MDS nurses (2) will immediately contact the hall nurse and the Administrator. On 09/19/2014 at 7:10 PM the credible allegation was validated and Immediate Jeopardy was abated at 7:35 PM when interviews with nursing staff revealed awareness of emergent changes in condition and who to contact. Staff verified training had been received, that changes in condition were to be documented in the medical record, the physician should be notified and the resident transferred for acute care as indicated. Interviews revealed alert and oriented residents had been quarried about any concerns of mistreatment.	F 223			
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews and physician interviews, the facility	F 309	F309-Assessment	10/20/14	

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F 309	<p>Continued From page 39</p> <p>failed to identify the need for medical intervention and failed to immediately initiate emergency medical services for 1 of 4 residents (Resident #1) reviewed for an acute change of condition. Immediate jeopardy began on 09/12/2014 when the resident was found to have a purple face, blue lips, bleeding out of both ears, a bruise on her face, and staff delayed calling for transport to the hospital for approximately five hours after the change in condition was recognized. The Administrator was notified of the Immediate Jeopardy on 9/18/14 at 7:41 PM. Immediate Jeopardy was removed on 09/19/2014 at 7:35 PM. The facility remained out of compliance at a lower scope and severity of (D), isolated with potential for more than minimal harm that is not immediate jeopardy, while the facility completes the staff training required. The facility was in the process of monitoring the implementation of their corrective action.</p> <p>The findings included:</p> <p>A review of the facility's protocol for "NOTIFICATION OF CHANGES" dated 1/2009, included, "The facility will 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 which results in injury and has the potential for requiring physician intervention * A significant change in the resident's physical, mental, or psychosocial status" The Notification of Change protocol had an attached section entitled, "ACUTE EPISODE" dated 8/2012. The Acute Episode protocol read as follows: "It is the policy of the facility to be alert to any change in resident condition and to respond in an appropriate manner to ensure satisfactory intervention treatment for the resident." The</p>	F 309	<p>" Resident #1 was observed on 9/12/14 at approximately 6:30am by CNA (NA) with flushed skin and blood coming from resident ears. CNA notified nurse of resident flushed skin and blood coming from resident #1 ears on 9/12/14. Nurse assessed resident #1 at approximately 6:45 am on 9/12/14 with O2 sats range at 92% and skin color slightly purple. Nurse applied O2 and sats went to 97%, blood pressure 134/58 and heart rate 98. Resident #1 was reassessed on 9/12/14 at approximately 7:00 am by the third shift and first shift nurse with no active bleeding noted. First shift nurse continued to assess resident #1 on 9/12/14 at 8:30 am with no active bleeding observed. First shift nurse reassessed resident #1 on 9/12/14 around 9:30 am and observed a rash on resident face and light discoloration to resident face. On 9/12/14 9:30am the MD (physician) office nurse was made aware by first shift nurse of bleeding from resident #1 ears at 6:30am, rash on face, and light discoloration to resident face. Resident #1 was assessed by first shift nurse again at approximately 10:30 am an observed darkening under resident's eyes. On 9/12/14 first shift nurse contacted MD office nurse again and notified of darkening under resident's eyes. Order received from MD office nurse on 9/12/14 approximately at 11:48am MD order was written to send resident to ER. Hall nurse assigned to resident #1 during the acute change was drug tested and suspended by the Administrator on 9/15/14. CNA assigned to resident #1 during the acute change in</p>		

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F 309	<p>Continued From page 40</p> <p>Notification of Change protocol also had an attached section entitled, "NOTIFICATION OF PHYSICIAN FOR CHANGE IN RESIDENT 'SCONDITION" dated 8/2012 which read, "It is the policy of the facility to notify the physician when a significant change in a resident's condition occurs with documentation contained within the medical record."</p> <p>Resident #1 was admitted to the facility on 04/18/2012 from an acute care hospital. Her cumulative diagnoses included multiple contractures, dysphagia, muscle weakness, anoxic brain damage, depression, cerebral artery occlusion with infarct, and asthma. The most recent Minimum Data Set (MDS) dated 6/19/14, indicated the resident had long and short term memory problems and decision making ability was severely cognitively impaired. The MDS indicated the resident was rarely or never understood, required total assistance for bed mobility, had contractures in both lower extremities and could not ambulate. Per the MDS, the staff assessment of the resident's mood did not indicate the presence of any symptoms of depression, mood disorder or behaviors.</p> <p>Resident#1's Plan of Care, most recently updated on 7/21/2014, indicated the resident had feelings of depression and ineffective coping characterized by tearfulness, anxiety and repetitive motor agitation.</p> <p>Documentation in Resident #1's record was reviewed for the events on 09/12/2014. An entry dated 09/12/2014 at 12:15 AM, indicated the resident was in bed with her eyes closed, that she was incontinent and required staff turning and repositioning. The entry stated there were no</p>	F 309	<p>condition was suspended and drug tested by the Administrator on 9/16/14. An inservice was initiated on 9/12/14 and an additional inservice was initiated on 9/16/14 with both in-services completed at 100% by 9/18/14 with all other licensed nurses by the Staff Facilitator (Staff Educator) to include LPN #1, LPN #2, LPN #3, and LPN #4 regarding assessing acute changes in condition, sending resident out if unable to contact MD, examples of acute changes to include abnormal bleeding, notification to physician by telephone when an acute change in condition to include cognitive status, behavior, immune system response, normal body system functioning, changes in cognitive status, changes in behavior, changes in oral intake to include fluids, changes in immune system, changes in normal body functioning, Panic laboratory values, resident's condition warrants based upon nurse's assessment; If you are unable to reach Attending Physician, you may call On-call for physician; If you are unable to reach attending or on-call physician, you may call the facility's Medical Director. Notification of the physician of these types of changes in a resident's condition by fax is not acceptable. If it warrants send the resident to the ER (Emergency Room). Handouts given to staff for reference.</p> <p>" Acute Change is defined as anything outside the norm for a resident to include but not limited to abnormal bleeding, skin color changes, changes in behaviors,</p>		

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F 309	<p>Continued From page 41</p> <p>acute changes or signs of distress. The note was signed by Licensed Practical Nurse (LPN)#1.</p> <p>The next entry was dated 09/12/2014 at 6:51 AM and read, "CNA (Nursing Assistant) informed me that resident was bleeding out of her ears. Resident had blood coming out of her ears and her face was slightly purple." The note also stated the Resident's oxygen saturation level (O2 sat) was 92%. After the resident was given oxygen the O2 sat was 97%, the blood pressure was 134/58 and heart rate was 98. The note indicated the Director of Nursing (DON) was informed, a voicemail message had been left for the attending physician and the nurse was unable to contact the responsible party (RP). The note was signed by LPN#1.</p> <p>A physician's telephone order, dated 9/12/2014 at 11:48 AM stated Resident #1 was to be sent to the hospital emergency room for evaluation.</p> <p>At 12:05 PM on 09/12/2014 the progress note read, "Resident being assessed throughout the shift. No bleeding noted thus far, but a rashy area to upper face and dark circles to Bilat (both) eyes noted. Resident continues on 2L (2 liters) O2 via NC (nasal cannula). Resident grimacing more than usual. MD (physician) made aware. No answer at RP's number. DON made aware." This note was signed by LPN#2.</p> <p>A progress note dated 09/12/2014 at 12:15 PM read, "Resident being assessed throughout the shift. No bleeding noted thus far, but a rashy area to upper face and dark circles to Bilat eyes noted. Upon starting shift no black circle noted. Area around eyes appeared to slowly darken throughout the shift. Resident continues on 2L O2</p>	F 309	<p>change in mental alertness and orientation, increased weakness or fatigue, change in abilities to feed, bathe, or groom self, change is sitting balance, transfer, or walk, change in appetite, change in ability to chew/swallow food, difficulty with breathing, complaints of dizziness, change in bowel elimination habits, complaints of nausea and vomiting, and falls.</p> <p>" 100% of all current residents were physically observed for acute changes in condition to include changes in skin color and bleeding on 9/15/14 by DON, SDC nurse, QI nurse, MDS nurses (2) and facility consultant. Four concerns were noted during this audit and corrected by the treatment nurse on 9/15/14 and 9/16/14 with interventions placed, MD and RP notification, and documentation in the progress notes. Three months of nurse's notes were reviewed to ensure all documented acute changes in condition to include changes in skin color and bleeding have been addressed with appropriate interventions placed, Attending Physician notification and Responsible Party notification of the acute change on 9/15/14 by DON, SDC nurse, QI nurse, MDS nurses (2) and facility consultant. Two concerns were noted during this audit with reassessment of the resident by the treatment nurse on 9/16/14, no concerns observed during the reassessment, and documentation in the progress note.</p> <p>" An inservice was initiated with all</p>		

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F 309	<p>Continued From page 42</p> <p>via NC. Resident grimacing more than usual. MD made aware. No answer at RP's number. DON made aware." The note was signed by LPN#2.</p> <p>Review of an ambulance transportation "Patient Care Report" included, "Chief Complaint: Abdominal Pain. Primary Symptom: Pain. Patient found in bed in nursing home, pt (patient) was observed to be guarding her abdomen and had two black eyes, nurse stated she did not know how she got the black eyes and that they were not black yesterday" The transport note indicated on 09/12/2014 at 12:28 PM they departed from the nursing home and arrived at the hospital at 12:31 PM.</p> <p>The hospital Emergency Department exam report dated 09/12/2014 included, "Patient with petechiae to face and ecchymosis around eyes, blood from ears. There are bruises along the patient's throat that are suspicious for finger prints. I am concerned about elder abuse and attempted strangulation. Will notify DSS (Department of Social Services) and plan to admit patient for her safety until this situation can be investigated. Pt (patient) is nonverbal but when I ask her if anyone hurt her, her eyes began to tear up." The report was signed by Hospital Physician #1.</p> <p>The Radiology report (dated 09/12/2014) revealed the Computerized Tomography (CT) scan was negative for a fracture, there was no mass or hematoma and no other significant findings.</p> <p>During an interview on 09/19/2014 at 9:51 AM, Hospital Physician #1 discussed her findings regarding her examination of Resident #1 on the</p>	F 309	<p>CNAs to include NA #1 and NA #2, Housekeeping, Dietary, therapy staff and any agency/contracted staff on 9/16/14 and completed on 9/18/14 on all shifts by the Staff Facilitator regarding observation and reporting changes in resident's condition promptly to the staff nurse or supervisor, not leaving the resident during an emergency situation, and completion of The Early Warning Tool Stop and Watch tool by C.N.A's, licensed nurses, housekeeping, dietary, Therapy staff and any agency/contracted staff on any acute change in condition noted to include seems different than usual, talks or communicates less than usual, overall needs more help than usual, participated in activities less than usual, ate less than usual (not because of dislike of food), Drank less than usual, weight change, agitated or nervous more than usual, tired, weak, confused, or drowsy, change in skin color or condition, and help with walking, transferring, toileting more than usual and given to hall nurse. No staff will be allowed to work until they have received in-service. All newly hired C.N.A's, Housekeeping, Dietary, Therapy Staff and any newly assigned agency staff will be in-serviced in orientation regarding acute changes in condition. An inservice was initiated with 100% of license nurses to include agency nurses and LPN #1, LPN #2, LPN #3, and LPN #4 initiated on 9/12/14 and completed by 9/18/14, on assessment of acute changes in condition, sending resident out if unable to notify MD, notification to physician by telephone to</p>		

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F 309	<p>Continued From page 43</p> <p>afternoon of 09/12/2014. Hospital Physician #1 said that in addition to the bruising around her eyes and on her neck, Resident #1 also had a bruise on her upper arm when she came into the emergency department (ED). Hospital Physician #1 said, "We had to call the nursing home three times to get the list of medications" and added that Resident #1 wasn't on any medications that would have caused the petechiae or bruising. Hospital Physician #1 said, "Very few things will cause that petechial rash. It is forensically distinctive,- pathognomonic [specifically characteristic of a disease or condition; denoting a sign or symptom on which a diagnosis can be made]." The physician further stated, "The petechial rash is indicative of strangulation or a crushing force. I could not find anything else that would have caused it with this patient."</p> <p>The documentation from Resident #1's admitting hospital physician (Hospital Physician #2) dated 09/12/2014 included, "Her face appears atraumatic except for large periorbital, infraorbital ecchymosis (bruising under and around the eyes). Patient has a petechial rash from the upper lip up to the forehead." The document also indicated there was a little bit of petechial rash "on the left side of the neck." Hospital Physician #2's assessment included, "Petechial rash. Is it a case of elderly abuse? We spoke with the nursing home staff and they truly do not have any idea of what happened. Patient is not ambulatory. She is totally bedridden so there was no history of a fall. This has to be investigated and DSS will be called."</p> <p>Hospital Physician #2 was interviewed on 09/18/2014 at 10:44 AM and said, "This patient has so many unexplained injuries. These were</p>	F 309	<p>include second shift, third shift and weekends; when an acute changes in condition occur, including abnormal bleeding, changes in cognitive status, behavior, oral changes to include fluids, immune system response, normal body system functioning, Panic laboratory values, resident's condition warrants based upon nurse's assessment; If you are unable to reach Attending Physician, you may call On-call for physician; If you are unable to reach attending or on-call physician, you may call the facility's Medical Director. Notification of the physician of these types of changes in a resident's condition by fax is not acceptable. In-service was initiated 9/18/14 and completed on 9/21/14 with all license nurses to include LPN #1, LPN #2, LPN #3, and LPN #4 by Staff Facilitator on notifying the DON of all acute changes in condition. All newly hired licensed nurses and newly assigned agency staff will be in-serviced in orientation on notification to the physician of acute changes in resident condition, and notifying DON of all acute changes in condition.</p> <p>" The staff nurse will follow up on completed Early Warning Tools by assessing the resident, reporting to Attending Physician and Responsible Party, appropriate interventions initiated and documentation is in progress notes. The Early Warning Tool will be placed in the DON mailbox for review to ensure that the resident was assessed, reporting to Attending Physician and Responsible</p>		

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F 309	<p>Continued From page 44</p> <p>life-threatening injuries." When asked about possible causes for the bleeding from the ears, Hospital Physician #2 stated that bleeding from the ears was usually associated with a skull fracture or very forceful coughing. She further stated that petechiae is often found with strangulation or forceful vomiting and that the nursing home had said there was no vomiting. Hospital Physician #2 said that tests showed no cranial fracture but there was swelling of the soft tissue in her face and neck, bruising, and subconjunctival hemorrhaging. Hospital Physician #2 said, "I don't know of anything that could cause all of that other than strangulation when you rule out a fall, vomiting or forceful cough." Hospital Physician #2 indicated Resident #1 was still in the hospital.</p> <p>The facility provided their investigation and written statements from the facility staff taken on 09/15/2014 through 09/17/2014. After review of each written statement, the facility staff were interviewed during the survey.</p> <p>On 09/16/2014 Nursing Assistant (NA) #1 wrote, "(Resident #1) had no falls on 11-7 that I'm aware of in the last 2 wks (weeks)." An interview was conducted with NA #1 on 09/18/2014 at 10:42 AM. NA#1 indicated she was working the 11 PM to 7 AM shift, had provided care for Resident #1, and was the person who discovered Resident #1 with bleeding ears. NA#1 stated that the resident required total care and when agitated, would pull off her nightgown and incontinent brief. NA #1 stated during that night the resident had been agitated and ripping her brief. At approximately 6:40 AM, NA #1 looked in to check on the resident and found her with the gown pulled up over her face. NA#1 said Resident #1 was facing</p>	F 309	<p>Party was completed, appropriate interventions initiated and documentation is in progress notes. The staff nurse is responsible to assess, document, provide appropriate interventions and notify Attending Physician and Responsible Party of any acute changes in condition noted. The staff nurse will implement appropriate interventions based on the needs of the resident and notify Attending Physician and Responsible Party. When a LPN is on duty and the resident has had an acute change in condition but the resident is not sent to the hospital, the LPN must notify the RN and the RN must re-assess the resident to insure the acute change in condition does not warrant hospitalization. All staff nurses will document all acute changes in condition on the 24 hour report/communication board daily. The staff nurses will communicate all acute changes utilizing the communication board during shift report. Staff will notify the DON or on-call nurse of any acute changes. DON, QI nurse, Staff facilitator and MDS nurses were in-serviced by the Administrator on 9/16/14 concerning when they are on-call and they receive a call concerning a change in condition of a resident that they are to ask more questions, if needed, to get a clear picture of what is occurring with the resident. Staff Facilitator will include in newly hired Nurses orientation and newly assigned agency staff, nursing scenarios to include acute changes, such as: S/SX UTI□s, S/SX hyper/hypoglycemia, difficulty breathing, decreased ability to perform ADL□s,</p>		

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F 309	<p>Continued From page 45</p> <p>the door, laying on her right side and her sheet was on the floor. NA#1 saw blood on sheet, and spots of blood, close together on the pillow in front of her face. "I had no idea where the blood was coming from, so I went to look." NA #1 turned the resident on her back, "and the blood poured out of her (left) ear" so she turned her on her back and went to look for the nurse. NA#1 reported that neither of the nurses were available but the NA from the 100 hall was doing care and she motioned for her to come with her to Resident #1's room. NA#1 and NA#2 went back to the room and when NA#2 saw the resident she left to go get LPN#1. NA#1 stated that when she started to clean Resident #1 up and turned her over blood came out of the other ear. NA#1 said, "The nurse sometimes has to give her medication to get her to calm. But not that night, she was up all night long, restless." NA#1 said that she had not reported the resident's restlessness to the nurse.</p> <p>Nursing Assistant (NA) #2's undated statement included, "I got done caring for my residence (sic) and as I was making my way to the back nurses station I bumped into (NA#1) who said (Resident #1) was bleeding. As I enter the room I noticed that her face was blue and that their(sic) was blood in her ears." NA#2's statement included that the resident was scratching her face. NA#2 left to find nurse #1 who told her to get the resident's vital signs. NA#2 was interviewed during the survey, on 9/18/2014 at 5:20 PM and said, "I was through with my rounds and saw (NA#2) was coming out of her room and she said (Resident #1) was bleeding and she didn't know why or where. So I followed into the room and her (Resident #1's) face was blue and we noticed her bleeding." NA#2 said, "I left to go</p>	F 309	<p>change in bowel/urinary patterns, unusual bleeding from the ears to insure nurse is competent in identifying acute changes in condition, notifying the MD and contacting the DON. Staff Facilitator will provide additional training on recognizing and assessing for acute changes in condition for any nurse that is deemed incompetent prior to taking an assignment. This will occur with all new hires, LPN□s and RN□s.</p> <p>Current residents will be physically observed for acute changes in condition, 24 hour/communication board will be reviewed, and nurse notes will be reviewed weekly X□s 4 weeks and then monthly X□s 3 months to insure that if resident has a change in condition that the resident has been assessed, MD and RP was notified timely, and any orders given were initiated timely utilizing an Acute Change in Condition Monitoring QI Tool. This will be completed by DON, QI nurse, staff facilitator, and/or MDS nurses.</p> <p>Directed inservicing to be provided to all facility licensed nurses on all shifts to include change in condition and getting resident medical treatment. Inservicing will be provided in the facility by a MSN qualified instructor through Eastern Carolina AHEC on October 15, 2014.</p> <p>The Executive QI committee (Administrator, DON, QI, MDS, and any other appropriate persons) will meet weekly x□s 4 weeks and then monthly to</p>		

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F 309	Continued From page 46 find a nurse and she told me to get her vitals." On 09/15/2014 LPN#1 wrote, "Between the times of 6:30-6:45ish am, CNA came and told me that (Resident #1) had blood coming out of her ear and was slightly purple in her face. I ran to the room with my vital sign equipment. Her pulse was high and her O2 was in the low 90s after getting oxygen put on her at 2L resident's vitals were re-taken and after were good within normal limits." LPN#1 was interviewed during the survey on 09/18/2014 at 11:14 AM, and said she had given the resident her scheduled medications (Synthroid and Prilosec) around 6AM and had not noticed any agitation at that time or earlier in the night. LPN#1 stated that the resident had not had problems during the night and no one had reported any fall or agitation with regard to Resident #1. When asked how she had learned of the resident's condition that morning LPN#1 said, "(NA#2) reported it to me. She said (Resident #1) was slightly purple in her face and she had blood coming out of her ear. I think it was her left ear. I got vital signs right away. She had blood coming out of her ear and she was purple in her face like she wasn't getting enough oxygen." When asked about the amount of blood coming from the resident's ears LPN#1 replied, "I would say it was like a nose bleed. It wasn't gushing but was actively flowing." LPN#1 stated that she called LPN#2 and #3. She indicated LPN #2 went to get the oxygen and the resident's oxygen saturation level "started to come up and color started to come back and the bleeding had stopped." LPN#1 stated there were no other residents in the hallways and when asked what she thought had occurred she stated, "I have no idea." LPN#2 said, "I called the DON and I told her everything that was going on, - the blood,	F 309	review the Acute Change in Condition Monitoring QI Tool to determine trends and/or issues that may need further interventions put in place. To determine that need for further and/or frequency of monitoring.		

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F 309	<p>Continued From page 47</p> <p>purple and O2 and that her vital signs were okay. I called the doctor and left a message. The next nurse came on and I told her everything." When asked about what might cause bleeding from both ears, LPN#1 said, "I don't know."</p> <p>On 09/15/2014 LPN#2's written statement included that LPN#1 had called for assistance and when she entered the resident's room the NAs were changing the bed. "The ring of blood I saw was approximately four inches in diameter. (LPN#1 stated that resident was bleeding from her ears. Resident's lips were bluish tinged so I told (LPN#1) I would get oxygen." The statement indicated that LPN#2 told LPN#1 to call Resident #1's attending physician. LPN#2 was interviewed during the survey on 9/19/14 at 3:50 PM. LPN#2 said "I did see blood, probably the size of a grapefruit, maybe 3-4 inches on the sheet or pillowcase. The resident's lips were a little blue tinged so I went to get some oxygen." LPN#2 stated she herself did not do an assessment of Resident#1 and that LPN#1 applied the oxygen and took vital signs. When asked about what might cause bleeding from both ears LPN#2 said, "When (LPN#1) told me she couldn't get the doctor- that he didn't answer, I told her to call the DON." When asked if she told LPN #1 to call the hospital to contact the physician outside office hours, LPN#2 indicated she only told her to call the doctor and added "I can't tell you that I did tell her or that I didn't tell her on any prior occasion."</p> <p>LPN #3 provided a written statement for the facility on 09/17/2014. The statement included that when LPN#3 arrived at the 200 hall nursing station, LPN#1 told her that everything was okay. LPN#3 went into Resident #1's room and saw blood in her ear and on the pillowcase. LPN#3</p>	F 309			

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F 309	<p>Continued From page 48</p> <p>was interviewed during the survey on 09/19/2014 at 4:15 PM. LPN#3 said that on the morning of 09/12/2014 she had been giving report when someone paged for all nurses to go to the 200 hall. "She (LPN#1) didn't call any kind of a code or anything so we just walked there." LPN#3 said that when she arrived at the nursing station, "(LPN#2) said 'That's okay, we got it.'" LPN#3 stated she went to Resident #1's room and saw blood in the resident's right ear. LPN## stated she did not do an assessment of the resident but did ask the NAs in the room what happened, "and they all said they didn't know." LPN#3 said she observed fresh blood, "about the size of a donut" on the linen and the resident was grimacing. She said, "I didn't know what to think" and added "I would have called the doctor and then called the DON and if the doctor didn't call back then I would have called the DON again."</p> <p>On 09/15/2014 the DON wrote that on 09/12/2014 at approximately 6:50 AM, "I received a call from (LPN#1). She stated that (Resident #1) had some blood coming out of her ears and she didn't know what to do. I said you need to call the doctor and make sure to call the R.P. (Responsible Party) as well. She stated okay. I got to the facility (approximately) 8:30 on 9/12/14 and I had not heard anything else regarding resident status until 7-3 nurse (LPN#4) stated that she had sent the resident to the ER for rash on face and dark circles forming under eyes." The DON was interviewed during the survey on 09/18/2014 at 5:35 PM, and said, "I got a phone call from (LPN#1) at about 6:45-6:50. She said (Resident #1) had blood from her ear and she didn't know what to do. I told her she needed to call the doctor and report it. " The DON stated that she did not inquire further about</p>	F 309			

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F 309	<p>Continued From page 49</p> <p>the blood from the resident's ears and said, "I thought it was a skin tear or scratch or something. I didn't think it was anything emergent but I did tell her to call the doctor." The DON added, "I should have been more inquisitive." The DON said she spoke to the day shift nurse (LPN#4) and learned that the bleeding from the ears had stopped but the DON did not go to the room to assess the resident herself. The DON stated that a lot of blood from a resident's ears could be a sign of a head injury and said, "I would have expected her (LPN#1) to send her to the hospital when they saw the amount of blood I have since learned of." The DON said if the nurse did not hear back from the physician that the resident should have been sent to the hospital for evaluation. The DON said she learned that LPN#1 had called the physician's office and left a message on the answering machine. Upon request the DON reviewed the physician numbers posted at the nursing station and said the off-hours paging number for that doctor was not posted at the desk. The DON also indicated that none of the Registered Nurses in the building on that Friday morning of 09/12/2014, had assessed Resident #1.</p> <p>LPN#4's undated statement indicated she was told by the off-going 11-7 nurse that Resident #1 had been bleeding from her ears. "The nurse mentioned to another that it was a lot. She attempted to get in touch with the resident's doctor but never talked to him." LPN#4's statement also included, "All the while in the back of my mind I'm thinking her doctor was paged at some point and he should be calling soon." The statement indicated LPN#4 had checked the resident at approximately 8:30 AM and there was no active bleeding from the ears</p>	F 309			

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F 309	Continued From page 50 and no other symptoms but about an hour later the resident had developed a rash around her eyes and there was some discoloration on her face. " I then called the MD's (physician's) office to see why they hadn't called and to tell them about the rash. I spoke with the MD's nurse and told her about the bleeding from the previous shift as well. She stated she would let him know and call back. Not even an hour later resident began to have dark circles under her eyes like blood had pooled there. I called the MD's office back to let them know and found out from the nurse that the MD said that he never received any pages or calls from anyone about the matter. I was instructed to send the resident out to the hospital for evaluation. Resident was alert with eyes open when she left. I was asked by MD's office if resident has sustained any falls but I was unaware of any recent falls." LPN#4 was interviewed during the survey on 09/18/2014 at 10:08 AM. She stated when she examined Resident #1 she didn't see any blood but there was a light purple discoloration on the right side of her face and the discoloration was on her forehead too. "I was waiting for the doctor to call back and I continued with my med-pass." LPN#4 stated that about one and a half hours later she checked the resident and the oxygen was still on at 2L per minute. She said the treatment nurse went in to change a dressing and identified the rash on the resident's face as petechiae. LPN#4 said she called the attending physician's nurse and then about an hour and a half later she noted the dark circles forming under her eyes and called the physician's office again. The resident went out to the hospital at approximately noon. LPN#4 said, "I thought she had fallen when her eyes started to turn black but night shift said she had not fallen and she was in bed all day for us	F 309			

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F 309	<p>Continued From page 51</p> <p>and I know she didn't have a fall. I was thinking closed head injury or that she had fallen." She added, "I called the DON to tell her I was sending (Resident #1) out."</p> <p>During an interview on 09/19/2014 at 5:15 PM, the Administrator said, "I would have expected (LPN#1) to do a full assessment. I would have expected her to call 911. I would have expected (the DON) to have more discussion regarding that assessment."</p> <p>During an interview on 09/25/2014 at 9:11 AM, Resident #1's attending physician in the facility stated, "I was informed that the day nurse had been waiting for a call back from me but I didn't know anything about an earlier call about the bleeding from both ears earlier." The physician stated the resident was not on any medications that would cause bleeding from the ears or petechiae. The physician said, "I would expect the nurse to send her to the hospital to see why she was bleeding from the ears." He added, "This (bleeding from the ears) was definitely an emergency. They have to make sure someone with experience is there to take charge."</p> <p>The Administrator was notified of the Immediate Jeopardy for F309 on 9/18/14 at 7:41 PM.</p> <p>The facility provided the following credible allegation of compliance on 9/19/14 at 5:00 PM.</p> <p>CREDIBLE ALLEGATION OF COMPLIANCE F309-Assessment</p> <p>Resident #1 was observed on 9/12/14 at approximately 6:30am by NA (NA) with flushed skin and blood coming from resident ears. NA notified nurse of resident flushed skin and blood</p>	F 309		

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F 309	Continued From page 52 coming from resident #1 ears on 9/12/14. Nurse assessed resident #1 at approximately 6:45 am on 9/12/14 with O2 sats range at 92% and skin color slightly purple. Nurse applied O2 and sats went to 97%, blood pressure 134/58 and heart rate 98. Resident #1 was reassessed on 9/12/14 at approximately 7:00 am by the third shift and first shift nurse with no active bleeding noted. First shift nurse continued to assess resident #1 on 9/12/14 at 8:30 am with no active bleeding observed. First shift nurse reassessed resident #1 on 9/12/14 around 9:30 am and observed a rash on resident face and light discoloration to resident face. On 9/12/14 9:30am the MD (physician) office nurse was made aware by first shift nurse of bleeding from resident #1 ears at 6:30am, rash on face, and light discoloration to resident face. Resident #1 was assessed by first shift nurse again at approximately 10:30 am an observed darkening under resident's eyes. On 9/12/14 first shift nurse contacted MD office nurse again and notified of darkening under resident's eyes. Order received from MD office nurse on 9/12/14 approximately at 11:48am MD order was written to send resident to ER. Hall nurse assigned to resident #1 during the acute change was drug tested and suspended by the Administrator on 9/15/14. NA assigned to resident #1 during the acute change in condition was suspended and drug tested by the Administrator on 9/16/14. An inservice was initiated on 9/12/14 and an additional inservice was initiated on 9/16/14 with both in-services completed at 100% by 9/18/14 with all other licensed nurses by the Staff Facilitator (Staff Educator) regarding assessing acute changes in condition, sending resident out if unable to contact MD, examples of acute changes to include abnormal bleeding, notification to physician by telephone when an	F 309			

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F 309	<p>Continued From page 53</p> <p>acute change in condition to include cognitive status, behavior, immune system response, normal body system functioning, changes in cognitive status, changes in behavior, changes in oral intake to include fluids, changes in immune system, changes in normal body functioning, Panic laboratory values, resident's condition warrants based upon nurse's assessment; If you are unable to reach Attending Physician, you may call On-call for physician; If you are unable to reach attending or on-call physician, you may call the facility's Medical Director. Notification of the physician of these types of changes in a resident's condition by fax is not acceptable. If it warrants send the resident to the ER (Emergency Room). Handouts given to staff for reference. No nurse will be allowed to work without first receiving the in-services.</p> <ul style="list-style-type: none"> Acute Change is defined as anything outside the norm for a resident to include but not limited to abnormal bleeding, skin color changes, changes in behaviors, change in mental alertness and orientation, increased weakness or fatigue, change in abilities to feed, bathe, or groom self, change in sitting balance, transfer, or walk, change in appetite, change in ability to chew/swallow food, difficulty with breathing, complaints of dizziness, change in bowel elimination habits, complaints of nausea and vomiting, and falls. 100% of all current residents were physically observed for acute changes in condition to include changes in skin color and bleeding on 9/15/14 by DON, SDC (Staff Development Coordinator) nurse, QI (Quality Improvement) nurse, MDS nurses (2) and facility consultant. Four concerns were noted during this audit and corrected by the treatment nurse on 	F 309			

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F 309	<p>Continued From page 54</p> <p>9/15/14 and 9/16/14 with interventions placed, MD and RP notification, and documentation in the progress notes. Three months of nurse's notes were reviewed to ensure all documented acute changes in condition to include changes in skin color and bleeding have been addressed with appropriate interventions placed, Attending Physician notification and Responsible Party notification of the acute change on 9/15/14 by DON, SDC nurse, QI nurse, MDS nurses (2) and facility consultant. Two concerns were noted during this audit with reassessment of the resident by the treatment nurse on 9/16/14, no concerns observed during the reassessment, and documentation in the progress note.</p> <p>An inservice was initiated with all NAs, Housekeeping, Dietary, therapy staff and any agency/contracted staff on 9/16/14 on all shifts by the Staff Facilitator regarding observation and reporting changes in resident's condition promptly to the staff nurse or supervisor, not leaving the resident during an emergency situation, and completion of The Early Warning Tool "Stop and Watch" tool by N.A's, licensed nurses, housekeeping, dietary, Therapy staff and any agency/contracted staff on any acute change in condition noted to include seems different than usual, talks or communicates less than usual, overall needs more help than usual, participated in activities less than usual, ate less than usual (not because of dislike of food), Drank less than usual, weight change, agitated or nervous more than usual, tired, weak, confused, or drowsy, change in skin color or condition, and help with walking, transferring, toileting more than usual and given to hall nurse. No staff will be allowed to work until they have received in-service. All newly hired N.A's, Housekeeping, Dietary,</p>	F 309			

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F 309	<p>Continued From page 55</p> <p>Therapy Staff and any newly assigned agency staff will be in-serviced in orientation regarding acute changes in condition. An inservice was initiated with 100% of license nurses to include agency nurses initiated on 9/12/14, on assessment of acute changes in condition, sending resident out if unable to notify MD, notification to physician by telephone to include second shift, third shift and weekends; when an acute changes in condition occur, including abnormal bleeding, changes in cognitive status, behavior, oral changes to include fluids, immune system response, normal body system functioning, Panic laboratory values, resident's condition warrants based upon nurse's assessment; If you are unable to reach Attending Physician, you may call On-call for physician; If you are unable to reach attending or on-call physician, you may call the facility's Medical Director. Notification of the physician of these types of changes in a resident's condition by fax is not acceptable. In-service was initiated 9/18/14 by Staff Facilitator on notifying the DON of all acute changes in condition. All newly hired licensed nurses and newly assigned agency staff will be in-serviced in orientation on notification to the physician of acute changes in resident condition, and notifying DON of all acute changes in condition.</p> <p>The staff nurse will follow up on completed Early Warning Tools by assessing the resident, reporting to Attending Physician and Responsible Party, appropriate interventions initiated and documentation is in progress notes. The Early Warning Tool will be placed in the DON mailbox for review to ensure that the resident was assessed, reporting to Attending Physician and Responsible Party was completed, appropriate interventions initiated and documentation is in</p>	F 309			

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

PRINTED: 10/14/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/19/2014
NAME OF PROVIDER OR SUPPLIER CAROLINA RIVERS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540		
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F 309	Continued From page 56 progress notes. The staff nurse is responsible to assess, document, provide appropriate interventions and notify Attending Physician and Responsible Party of any acute changes in condition noted. The staff nurse will implement appropriate interventions based on the needs of the resident and notify Attending Physician and Responsible Party. When a LPN is on duty and the resident has had an acute change in condition but the resident is not sent to the hospital, the LPN must notify the RN and the RN must re-assess the resident to insure the acute change in condition does not warrant hospitalization. All staff nurses will document all acute changes in condition on the 24 hour report/communication board daily. The staff nurses will communicate all acute changes utilizing the communication board during shift report. Staff will notify the DON or on-call nurse of any acute changes. DON, QI nurse, Staff facilitator and MDS nurses were in-serviced by the Administrator on 9/16/14 concerning when they are on-call and they receive a call concerning a change in condition of a resident that they are to ask more questions, if needed, to get a clear picture of what is occurring with the resident Staff Facilitator will include in newly hired Nurses orientation and newly assigned agency staff, nursing scenarios to include acute changes, such as: S/SX (signs and symptoms) UTIs (urinary tract infections), S/SX hyper/hypoglycemia, difficulty breathing, decreased ability to perform ADLs, change in bowel/urinary patterns, unusual bleeding from the ears to insure nurse is competent in identifying acute changes in condition, notifying the MD and contacting the DON. Staff Facilitator will provide additional training on recognizing and assessing for acute changes in condition for any nurse that is deemed incompetent prior to taking an	F 309			

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F 309	Continued From page 57 assignment. This will occur with all new hires, LPN's and RN's. On 09/19/2014 at 7:10 PM the credible allegation was validated and Immediate Jeopardy was abated at 7:35 PM when interviews with nursing staff revealed awareness of emergent changes in condition. Staff verified training had been received, that changes in condition were to be documented in the medical record, an RN was to be involved in the assessment, the physician should be notified and the resident transferred for acute care as indicated. Interviews revealed that if the attending or on-call physician could not be reached, the facility's Medical Director should be called. The number for paging the physicians after regular business hours was posted at the nursing station.	F 309			