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	345434	A. BUILDING _____ B. WING _____	C 09/11/2014

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CARVER LIVING CENTER	321 EAST CARVER STREET DURHAM, NC 27704

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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 this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, emergency medical services (EMS) report, and staff and physician interviews, the facility failed to immediately notify	F 157	The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation of our intent to correct the practices identified as deficient. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is filing this document in order to comply with its obligations as a provider participating in the Medicare/Medicaid program(s). **F 157** **Corrective action for residents found to have been affected by this deficiency:** Resident #186 no longer resides at this facility. **Corrective action for residents that may be affected by this deficiency:** 1. A 100% audit was completed on 9/10/14 and again on 9/11/14 by the nurse management team (director of nursing (DON), assistant director of nursing (ADON), 2 unit managers, wound nurse) a. The audit consisted of reviewing 100% of the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10/14/14

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

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F 157	Continued From page 1 the resident's physician of respiratory distress and continuous seizures, for 1 of 3 sampled residents reviewed for notification of change (Resident 186). The Immediate Jeopardy (IJ) began on 08/18/14 at 5:30 AM for Resident #186 when the resident was found with continuous seizures and respiratory distress. The Administrator was notified on 09/11/14 at 10:45 AM and the IJ was removed on 09/11/14 at 6:45 PM when the facility demonstrated it had implemented a credible allegation. The facility was left out of compliance at no actual harm with potential for more than minimal harm that is not immediate jeopardy [D] so that the facility can complete all staff in-services and monitoring systems could be implemented and included in the Quality Assurance Program. Findings included: Resident #186 was admitted to the facility on 01/27/12 with diagnoses of anoxic brain damage and seizure disorder. Review of the resident's physician order sheet for September 2014 revealed orders for Keppra, Vimpat and Klonopin. Keppra is an anticonvulsant, Vimpat is an anticonvulsant and Klonopin is a medication with anticonvulsant properties. A 07/10/14 quarterly minimum data set (MDS) indicated the resident was severely cognitively impaired. The care plan of 02/14/14 indicated seizures as a problem. The goal was resident will have airway open. Approaches included administer medications as ordered, observe for	F 157	nursing notes in the past 24 hours to ensure all residents experiencing any change of condition have had an appropriate nursing assessment and interventions, as indicated; physician notification for further guidance, as indicated and activation of EMS immediately, if indicated. i. 2 residents were started on an antibiotic with appropriate physician notification ii. 2 residents had a fall with appropriate physician notification iii. 1 hospice resident expired with appropriate physician notification iv. No other concerns were identified	

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F 157	Continued From page 2 side effects and effectiveness, neurological assessment as needed, notify MD as needed, maintain airway, and report seizures. On 09/10/14 at 5:45 PM, an interview was conducted with Nurse Aide (NA #1) who took care of the resident on 8/18/14 (third shift 11PM to 7AM). She stated the resident was fine during the night. "I went into the room on rounds about 5:30 AM and she was breathing hard." NA #1 indicated when she discovered the resident, she was having trouble breathing and jerking movements. NA #1 stated she went to get Nurse #1. In an interview with Nurse #1 on 09/10/14 at 11:51 AM, she stated she knew Resident #186 and had taken care of her prior to 08/18/14. She stated when she entered the room around 5:30 AM she observed the resident in respiratory distress and having seizures. The resident was in a supine (flat on her back) position. The nurse stated she took the resident's vital signs and her pulse oxygen saturation was low at 87 percent. She moved the resident to a 45 degree angle, and applied oxygen at 2 liters per minute. Nurse #1 stated "I gave her a breathing treatment with a Nebulizer." Nurse #1 stated the resident was unresponsive and actively having a continuous seizure. She stated the resident normally had some movements in her extremities but this was non-stop movements. Nurse #1 stated it sounded like she had a blockage in her throat. She stated there were no secretions coming from her mouth. She stated she did not attempt to suction the resident. Nurse #1 stated when a repeat oxygen saturation was done the oxygen was up to 89 or 90 percent and she increased the oxygen flow to 4 liters per minute. Nurse #1	F 157	2. On 9/10/14 and 9/11/14, a facility nurse manager has been assigned to each unit observing all facility residents which reside on those units for any concerns and or change in condition. i. No concerns were identified in regards to physician notification. 3. The physician and/or his nurse practitioner are in the facility Monday – Friday and while in the facility staff will notify them there. When they are not in the facility then they will be contacted through the on-call service. Physician notification is documented under the nursing charting in the medical record. 4. The physician is notified immediately in non-life threatening emergencies for further guidance and after EMS is activated in life threatening emergencies. **Measures that will be put into place to ensure that this deficiency does not recur:** 1. In-servicing for the nurses was started on 9/10/14 by the Clinical Resource Nurse and DON. On 9/11/14 40 nurses out	

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F 157	Continued From page 3 stated she did not call the resident's physician to report the seizure or see if oxygen should be increased at that time. Nurse #1 stated she called Emergency Medical Service (EMS) and stated probably sometime after 6:00 AM. Nurse #1 stated she did not call the physician at that time. She stated she called the physician and responsible party after the resident had left the facility with EMS at 8:14 AM. In nursing notes for 08/18/14 at 8:14 AM Nurse #1 documented, "Blood pressure 92/58 at 5:30 AM, pulse (rate) 64, temperature 98.2, respiratory rate 25 (breaths per minute), O2 (oxygen saturation) 87% on room air at 5:30 AM. Comments: Resident was wheezing, obvious gurgling, very lethargic/sleepy; difficult to arouse, has seizures. Nebulizer treatment given, O2 (oxygen) started at 4L/minute (Liters per minute). Seizure was non-stop and resident status did not improve. The Night Nurse in the front hall also helped in assessing the resident. EMS was called and resident was transported to [local hospital] via stretcher at 7:30 AM. Dr. [attending physician] notified; resident's daughter notified of resident's transfer". Review of Resident #186's 08/18/14, Emergency Medical Service (EMS) report Dispatch for the County services "was called at 6:53 AM on 08/18/14 reporting a resident with seizures, ambulance in route at 6:54 AM, the ambulance traveled one mile and arrived at the facility on 6:59 AM, emergency crew at bedside 7:05 AM. Chief Complaint, Seizures/Convulsion, Actively. Seizure duration greater than 5 minutes, seizure type- Grand Mal [for] 1 hour." (Taber's Medical Dictionary, 19th edition, describes Grand Mal as epilepsy, loss of consciousness with violent	F 157	of 52 have been in-serviced. No nurse will be able to work the floor until they are in-serviced. The in-service addressed the following: a. 24 Hour Report b. Alert Charting Process c. Infection Reports d. Change of Condition Guidelines- which included physician notification e. Documentation Guidelines- which included physician notification f. Appropriate assessment, interventions, follow up to interventions g. Emergency Procedures- Seizure Management h. Care of a Resident in Emergency Situations- which included but not limited to- initial assessment (objective and subjective symptoms), head injuries, lacerations, suspected fractures, burns, choking, shortness of breath, chest pain, syncope, seizures, dizziness, diabetic	

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F 157	Continued From page 4 movements of the extremities). The report continued, "lung sounds Left Wheeze/Rhonchi, and lung sounds right wheezes/ Rhonchi." [Rhonchi are described by Taber's as "A wheezing, snoring, or squeaking sound heard during auscultation (listening to chest with stethoscope) of a person with partial airway obstruction. Mucus or other secretion in the airway, bronchial hyperactivity that occlude respiratory passages."] In an interview with Nurse #2 on 09/10/14 at 12:21 PM, she stated that on 08/18/14 between 6:00 AM to 7:00 AM Nurse #1 came out in the hall to request help with Resident #186. She stated it must have been between 6 and 7 AM; she did not recall the exact time. Nurse #2 stated she went into Resident #186's room with Nurse #1 and observed the resident lying on the bed; she was shaking and having difficulty breathing. The resident had a blood pressure cuff on her right arm, and was getting oxygen via nasal cannula and was unresponsive. Nurse #2 stated "We woke her up using a sternal rub. She opened her eyes but never spoke. Her eyes were hazy and she was coughing." Nurse #2 stated she repeated the sternal rub. She stated the resident's body continued to shake during sternal rubs. Nurse #2 stated that she told Nurse #1 that they needed to call EMS. Nurse #2 stated Nurse #1 left the room to call EMS and prepare the discharge paperwork and she stayed in the room with the resident. She stated "I opened the closet and picked out an outfit for the resident. Then I washed her up and dressed her. I had to lay her down to get her shirt and pants on." Nurse #2 stated the resident was seizing and unresponsive while being bathed and dressed. Nurse #2 stated she was aware the resident was	F 157	coma/ketoacidosis, insulin shock/insulin reaction, acute psychotic behaviors, ingestion of toxins and physician notification. i. Emergency Procedures- which included physician notification **j. On 9/30/14 it was determined that 52 of the 52 nurses have received the in-service.** **k. As of 10/1/14 no new nurses have been hired in the facility.** **l. Any new nurses hired will receive education on physician notification during the orientation process.** 2. Two nurses were identified in this deficiency. a. One nurse was in-serviced on 9/11/14 **(see bullet points a-i above).** b. The other nurse has been suspended at this time pending an abuse allegation of neglect- she was suspended on 9/11/14. **The nurse's employment was terminated on 9/16/14 and the allegation of**	

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F 157	Continued From page 5 having continued seizures throughout the bath and dressing, however she continued on with the tasks because she wanted the resident to look nice to go to the hospital. Summary statement from EMS read: "Dispatched by 911 to a seizure. Arrived to find a 51 year old female actively seizing. Patient assessed as charted. Patient found in care of staff at local skilled facility with active seizure activity noted. Staff stated patient with hx (history) of same secondary to cardiac arrest and anoxic brain injury. Patient began seizing at approx (approximately) 5:30 this morning. IV (intravenous) access established x 1 attempt as charted and IV Versed administered per protocol." [Versed is a benzodiazepine used for status epilepticus, a continuous seizure activity without a pause.] "Seizure activity reduced however some residual focal activity remained. Patient continued on O2 at 10 liters per minute. During transport, second dose of IV Versed administered due to continued seizure activity. Seizure activity never fully ceased during EMS care and/or transport." Review of Resident #186's hospital records on 08/18/14 in part read, "The patient presented in status epilepticus. She required intubation for airway protection and admission to the ICU (intensive care unit). She was placed on a Versed gtt (drip), her Keppra was increased and she was Dilantin (another anticonvulsant) loaded. Her EEG (electroencephalogram, to view brain waves) indicated an underlying seizure disorder. She was felt to be having breakthrough seizures due to infection (aspiration pneumonia)". Patient was also suffering from septic shock due to possible aspiration pneumonia.	F 157	**neglect was substantiated.** 3. The Nurse Managers were in-serviced by the Clinical Resource Nurse on 9/10/14 on the following: a. 24 Hour Report- and how to use them b. Alert Charting Process c. Infection Reports d. Change of Condition Guidelines- which included physician notification e. Documentation Guidelines- which included physician notification f. Appropriate assessment, interventions, follow up to interventions g. Emergency Procedures- Seizure Management h. Care of a Resident in Emergency Situations- which included but not limited to- initial assessment (objective and subjective symptoms), head injuries, lacerations, suspected fractures, burns, choking, shortness of breath, chest pain, syncope,	

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F 157	Continued From page 6 Interview with the Director of Nursing (DON) on 09/10/14 at 2:13 PM, revealed that her expectation was if nursing staff observed a resident seizing that the resident should be raised to an upright position to protect airway, rolled toward the left side, and the nurse should call EMS if the seizure lasted more than 15 minutes. The DON stated Resident #186 was experiencing a medical emergency on 08/18/14 and laying the resident flat on her back for bathing and dressing the resident was inappropriate. The DON revealed the event was discussed on 08/19/14 at the morning meeting. She stated she saw the two hour time frame on the nurses' notes but was not concerned because sometimes it takes EMS time to stabilize a resident. She stated she thought the 'gurgling' was due to seizure activity. In an interview with the Medical Director on 09/10/14 at 12:52 PM, he acknowledged he was called by the nurse on 08/18/14 after the resident left for the hospital. He stated he would have expected to have been called by staff if the resident, with a history of seizures, had a seizure that lasted more than 5-10 minutes and EMS should be initiated immediately. The Administrator was notified of the Immediate Jeopardy on 9/11/14 at 10:45 AM. The facility provided the following credible allegation of compliance: RESIDENT IDENTIFIED 1. Resident #186 no longer resides at this facility. IDENTIFYING OTHER RESIDENTS AT RISK 1. A 100% audit was completed on 9/10/14 and	F 157	seizures, dizziness, diabetic coma/ketoacidosis, insulin shock/insulin reaction, acute psychotic behaviors, ingestion of toxins and physician notification. l. Emergency Procedures- which included physician notification 4. The nurse managers will continue with the AM Clinical Meeting Monday – Friday i. On Saturday and Sunday a nurse manager will be in the facility each day. ii. Physical rounds will be completed on each unit, every AM, prior to AM Clinical Meeting. A nurse manager will be speaking to the floor nurses regarding any resident change of	

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F 157	Continued From page 7 again on 9/11/14 by the nurse management team (director of nursing, assistant director of nursing, 2 unit managers, wound nurse) a. The audit consisted of reviewing 100% of the nursing notes in the past 24 hours to ensure all residents experiencing any change of condition have had an appropriate nursing assessment and interventions, as indicated; physician notification for further guidance, as indicated and activation of EMS immediately, if indicated. 1. 2 residents were started on an antibiotic with appropriate physician notification 2. 2 resident had a fall with appropriate physician notification 3. 1 hospice resident expired with appropriate physician notification 4. No other concerns were identified 2. On 9/10/14 and 9/11/14, a facility nurse manager has been assigned to each unit observing all facility residents which reside on those units for any concerns and or change in condition. 1. No concerns were identified in regards to MD notification. 3. The MD and/or his nurse practitioner are in the facility Monday - Friday and while in the facility staff will notify them there. When they are not in the facility then they will be contacted through the on-call service. MD notification is documented under the nursing charting in the medical record. 4. The MD is notified immediately in non-life threatening emergencies for further guidance and after EMS is activated in life threatening emergencies. PROCESSES IMPLEMENTED TO PREVENT FURTHER OCCURRENCES 1. In-servicing for the nurses was started on 9/10/14 by the Clinical Resource Nurse and DON.	F 157	conditions and physician notification for further guidance. In addition, the nurse manager will round on any residents which have had an identified change of condition. 5. A nurse manager will review the 24 hour report, alert charting log and nursing notes to ensure all change of conditions have been communicated to the physician, that guidance has been provided and documented in the medical record under the nurse charting tab. 6. **On 9/30/14 a "Quality Assurance Worksheet- Resident Status Change" audit form was implemented. The audit form will be completed by the nurse management team. The audit form includes, but is not limited to, physician notification. The audit form will be used daily by the nurse management team Monday through Friday times 12 weeks, then the nurse managers will use the audit form on 5 random charts weekly times 4 weeks.**	

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F 157	Continued From page 8 At this point 40 nurses out of 52 have been in-serviced. No nurse will be able to work the floor until they are in-serviced. The in-service addressed the following: a. 24 Hour Report b. Alert Charting Process c. Infection Reports d. Change of Condition Guidelines- which included physician notification e. Documentation Guidelines- which included physician notification f. Appropriate assessment, interventions, follow up to interventions g. Emergency Procedures- Seizure Management h. Care of a Resident in Emergency Situations- which included but not limited to- initial assessment (objective and subjective symptoms), head injuries, lacerations, suspected fractures, burns, choking, shortness of breath, chest pain, syncope, seizures, dizziness, diabetic coma/ketoacidosis, insulin shock/insulin reaction, acute psychotic behaviors, ingestion of toxins and physician notification. i. Emergency Procedures- which included physician notification 2. Two nurses were identified in this deficiency. a. One nurse was in-serviced on 9/11/14. b. The other nurse has been suspended at this time pending an abuse allegation of neglect- she was suspended on 9/11/14. 3. The Nurse Managers were in-serviced by the Clinical Resource Nurse on 9/10/14 on the following: a. 24 Hour Report- and how to use them b. Alert Charting Process c. Infection Reports d. Change of Condition Guidelines- which included physician notification	F 157	**Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** 1. During the AM Clinical Meeting all areas listed in #4 will be completed by the Nurse Management Team. a. The Nurse Management Team consists of the DON, ADON, 2 Unit Managers and 2 MDS Coordinators. b. The AM Clinical Meeting is held Monday-Friday at 8:45 AM. c. On Saturday and Sunday a nurse manager will be in the facility each day to complete the areas listed in #4. 2. During the AM Clinical Meeting any discrepancies identified will be documented, investigated and corrected immediately by the Nurse Management Team. 3. From any discrepancies identified further education and/or disciplinary action will occur with the staff member responsible. 4. The Clinical Resource Nurse will	

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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 this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, emergency medical services (EMS) report, and staff and physician interviews, the facility failed to immediately notify	F 157	The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation of our intent to correct the practices identified as deficient. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is filing this document in order to comply with its obligations as a provider participating in the Medicare/Medicaid program(s). **F 157** **Corrective action for residents found to have been affected by this deficiency:** Resident #186 no longer resides at this facility. **Corrective action for residents that may be affected by this deficiency:** 1. A 100% audit was completed on 9/10/14 and again on 9/11/14 by the nurse management team (director of nursing (DON), assistant director of nursing (ADON), 2 unit managers, wound nurse) a. The audit consisted of reviewing 100% of the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10/14/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 09/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	321 EAST CARVER STREET DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 the resident's physician of respiratory distress and continuous seizures, for 1 of 3 sampled residents reviewed for notification of change (Resident 186). The Immediate Jeopardy (IJ) began on 08/18/14 at 5:30 AM for Resident #186 when the resident was found with continuous seizures and respiratory distress. The Administrator was notified on 09/11/14 at 10:45 AM and the IJ was removed on 09/11/14 at 6:45 PM when the facility demonstrated it had implemented a credible allegation. The facility was left out of compliance at no actual harm with potential for more than minimal harm that is not immediate jeopardy [D] so that the facility can complete all staff in-services and monitoring systems could be implemented and included in the Quality Assurance Program. Findings included: Resident #186 was admitted to the facility on 01/27/12 with diagnoses of anoxic brain damage and seizure disorder. Review of the resident's physician order sheet for September 2014 revealed orders for Keppra, Vimpat and Klonopin. Keppra is an anticonvulsant, Vimpat is an anticonvulsant and Klonopin is a medication with anticonvulsant properties. A 07/10/14 quarterly minimum data set (MDS) indicated the resident was severely cognitively impaired. The care plan of 02/14/14 indicated seizures as a problem. The goal was resident will have airway open. Approaches included administer medications as ordered, observe for	F 157	nursing notes in the past 24 hours to ensure all residents experiencing any change of condition have had an appropriate nursing assessment and interventions, as indicated; physician notification for further guidance, as indicated and activation of EMS immediately, if indicated. i. 2 residents were started on an antibiotic with appropriate physician notification ii. 2 residents had a fall with appropriate physician notification iii. 1 hospice resident expired with appropriate physician notification iv. No other concerns were identified	

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F 157	Continued From page 2 side effects and effectiveness, neurological assessment as needed, notify MD as needed, maintain airway, and report seizures. On 09/10/14 at 5:45 PM, an interview was conducted with Nurse Aide (NA #1) who took care of the resident on 8/18/14 (third shift 11PM to 7AM). She stated the resident was fine during the night. "I went into the room on rounds about 5:30 AM and she was breathing hard." NA #1 indicated when she discovered the resident, she was having trouble breathing and jerking movements. NA #1 stated she went to get Nurse #1. In an interview with Nurse #1 on 09/10/14 at 11:51 AM, she stated she knew Resident #186 and had taken care of her prior to 08/18/14. She stated when she entered the room around 5:30 AM she observed the resident in respiratory distress and having seizures. The resident was in a supine (flat on her back) position. The nurse stated she took the resident's vital signs and her pulse oxygen saturation was low at 87 percent. She moved the resident to a 45 degree angle, and applied oxygen at 2 liters per minute. Nurse #1 stated "I gave her a breathing treatment with a Nebulizer." Nurse #1 stated the resident was unresponsive and actively having a continuous seizure. She stated the resident normally had some movements in her extremities but this was non-stop movements. Nurse #1 stated it sounded like she had a blockage in her throat. She stated there were no secretions coming from her mouth. She stated she did not attempt to suction the resident. Nurse #1 stated when a repeat oxygen saturation was done the oxygen was up to 89 or 90 percent and she increased the oxygen flow to 4 liters per minute. Nurse #1	F 157	2. On 9/10/14 and 9/11/14, a facility nurse manager has been assigned to each unit observing all facility residents which reside on those units for any concerns and or change in condition. i. No concerns were identified in regards to physician notification. 3. The physician and/or his nurse practitioner are in the facility Monday – Friday and while in the facility staff will notify them there. When they are not in the facility then they will be contacted through the on-call service. Physician notification is documented under the nursing charting in the medical record. 4. The physician is notified immediately in non-life threatening emergencies for further guidance and after EMS is activated in life threatening emergencies. **Measures that will be put into place to ensure that this deficiency does not recur:** 1. In-servicing for the nurses was started on 9/10/14 by the Clinical Resource Nurse and DON. On 9/11/14 40 nurses out	

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F 157	Continued From page 3 stated she did not call the resident's physician to report the seizure or see if oxygen should be increased at that time. Nurse #1 stated she called Emergency Medical Service (EMS) and stated probably sometime after 6:00 AM. Nurse #1 stated she did not call the physician at that time. She stated she called the physician and responsible party after the resident had left the facility with EMS at 8:14 AM. In nursing notes for 08/18/14 at 8:14 AM Nurse #1 documented, "Blood pressure 92/58 at 5:30 AM, pulse (rate) 64, temperature 98.2, respiratory rate 25 (breaths per minute), O2 (oxygen saturation) 87% on room air at 5:30 AM. Comments: Resident was wheezing, obvious gurgling, very lethargic/sleepy; difficult to arouse, has seizures. Nebulizer treatment given, O2 (oxygen) started at 4L/minute (Liters per minute). Seizure was non-stop and resident status did not improve. The Night Nurse in the front hall also helped in assessing the resident. EMS was called and resident was transported to [local hospital] via stretcher at 7:30 AM. Dr. [attending physician] notified; resident's daughter notified of resident's transfer". Review of Resident #186's 08/18/14, Emergency Medical Service (EMS) report Dispatch for the County services "was called at 6:53 AM on 08/18/14 reporting a resident with seizures, ambulance in route at 6:54 AM, the ambulance traveled one mile and arrived at the facility on 6:59 AM, emergency crew at bedside 7:05 AM. Chief Complaint, Seizures/Convulsion, Actively. Seizure duration greater than 5 minutes, seizure type- Grand Mal [for] 1 hour." (Taber's Medical Dictionary, 19th edition, describes Grand Mal as epilepsy, loss of consciousness with violent	F 157	of 52 have been in-serviced. No nurse will be able to work the floor until they are in-serviced. The in-service addressed the following: a. 24 Hour Report b. Alert Charting Process c. Infection Reports d. Change of Condition Guidelines- which included physician notification e. Documentation Guidelines- which included physician notification f. Appropriate assessment, interventions, follow up to interventions g. Emergency Procedures- Seizure Management h. Care of a Resident in Emergency Situations- which included but not limited to- initial assessment (objective and subjective symptoms), head injuries, lacerations, suspected fractures, burns, choking, shortness of breath, chest pain, syncope, seizures, dizziness, diabetic	

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F 157	Continued From page 4 movements of the extremities). The report continued, "lung sounds Left Wheeze/Rhonchi, and lung sounds right wheezes/ Rhonchi." [Rhonchi are described by Taber's as "A wheezing, snoring, or squeaking sound heard during auscultation (listening to chest with stethoscope) of a person with partial airway obstruction. Mucus or other secretion in the airway, bronchial hyperactivity that occlude respiratory passages."] In an interview with Nurse #2 on 09/10/14 at 12:21 PM, she stated that on 08/18/14 between 6:00 AM to 7:00 AM Nurse #1 came out in the hall to request help with Resident #186. She stated it must have been between 6 and 7 AM; she did not recall the exact time. Nurse #2 stated she went into Resident #186's room with Nurse #1 and observed the resident lying on the bed; she was shaking and having difficulty breathing. The resident had a blood pressure cuff on her right arm, and was getting oxygen via nasal cannula and was unresponsive. Nurse #2 stated "We woke her up using a sternal rub. She opened her eyes but never spoke. Her eyes were hazy and she was coughing." Nurse #2 stated she repeated the sternal rub. She stated the resident's body continued to shake during sternal rubs. Nurse #2 stated that she told Nurse #1 that they needed to call EMS. Nurse #2 stated Nurse #1 left the room to call EMS and prepare the discharge paperwork and she stayed in the room with the resident. She stated "I opened the closet and picked out an outfit for the resident. Then I washed her up and dressed her. I had to lay her down to get her shirt and pants on." Nurse #2 stated the resident was seizing and unresponsive while being bathed and dressed. Nurse #2 stated she was aware the resident was	F 157	coma/ketoacidosis, insulin shock/insulin reaction, acute psychotic behaviors, ingestion of toxins and physician notification. i. Emergency Procedures- which included physician notification **j. On 9/30/14 it was determined that 52 of the 52 nurses have received the In-service.** **k. As of 10/1/14 no new nurses have been hired in the facility.** **l. Any new nurses hired will receive education on physician notification during the orientation process.** 2. Two nurses were identified in this deficiency. a. One nurse was in-serviced on 9/11/14 **(see bullet points a-l above).** b. The other nurse has been suspended at this time pending an abuse allegation of neglect- she was suspended on 9/11/14. **The nurse's employment was terminated on 9/16/14 and the allegation of**	

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F 157	Continued From page 5 having continued seizures throughout the bath and dressing, however she continued on with the tasks because she wanted the resident to look nice to go to the hospital. Summary statement from EMS read: "Dispatched by 911 to a seizure. Arrived to find a 51 year old female actively seizing. Patient assessed as charted. Patient found in care of staff at local skilled facility with active seizure activity noted. Staff stated patient with hx (history) of same secondary to cardiac arrest and anoxic brain injury. Patient began seizing at approx (approximately) 5:30 this morning. IV (intravenous) access established x 1 attempt as charted and IV Versed administered per protocol." [Versed is a benzodiazepine used for status epilepticus, a continuous seizure activity without a pause.] "Seizure activity reduced however some residual focal activity remained. Patient continued on O2 at 10 liters per minute. During transport, second dose of IV Versed administered due to continued seizure activity. Seizure activity never fully ceased during EMS care and/or transport." Review of Resident #186's hospital records on 08/18/14 in part read, "The patient presented in status epilepticus. She required intubation for airway protection and admission to the ICU (intensive care unit). She was placed on a Versed gtt (drip), her Keppra was increased and she was Dilantin (another anticonvulsant) loaded. Her EEG (electroencephalogram, to view brain waves) indicated an underlying seizure disorder. She was felt to be having breakthrough seizures due to infection (aspiration pneumonia)". Patient was also suffering from septic shock due to possible aspiration pneumonia.	F 157	**neglect was substantiated.** 3. The Nurse Managers were in-serviced by the Clinical Resource Nurse on 9/10/14 on the following: a. 24 Hour Report- and how to use them b. Alert Charting Process c. Infection Reports d. Change of Condition Guidelines- which included physician notification e. Documentation Guidelines- which included physician notification f. Appropriate assessment, interventions, follow up to interventions g. Emergency Procedures- Seizure Management h. Care of a Resident in Emergency Situations- which included but not limited to- initial assessment (objective and subjective symptoms), head injuries, lacerations, suspected fractures, burns, choking, shortness of breath, chest pain, syncope,	

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F 157	Continued From page 6 Interview with the Director of Nursing (DON) on 09/10/14 at 2:13 PM, revealed that her expectation was if nursing staff observed a resident seizing that the resident should be raised to an upright position to protect airway, rolled toward the left side, and the nurse should call EMS if the seizure lasted more than 15 minutes. The DON stated Resident #186 was experiencing a medical emergency on 08/18/14 and laying the resident flat on her back for bathing and dressing the resident was inappropriate. The DON revealed the event was discussed on 08/19/14 at the morning meeting. She stated she saw the two hour time frame on the nurses' notes but was not concerned because sometimes it takes EMS time to stabilize a resident. She stated she thought the 'gurgling' was due to seizure activity. In an interview with the Medical Director on 09/10/14 at 12:52 PM, he acknowledged he was called by the nurse on 08/18/14 after the resident left for the hospital. He stated he would have expected to have been called by staff if the resident, with a history of seizures, had a seizure that lasted more than 5-10 minutes and EMS should be initiated immediately. The Administrator was notified of the Immediate Jeopardy on 9/11/14 at 10:45 AM. The facility provided the following credible allegation of compliance: RESIDENT IDENTIFIED 1. Resident #186 no longer resides at this facility. IDENTIFYING OTHER RESIDENTS AT RISK 1. A 100% audit was completed on 9/10/14 and	F 157	seizures, dizziness, diabetic coma/ketoacidosis, insulin shock/insulin reaction, acute psychotic behaviors, ingestion of toxins and physician notification. l. Emergency Procedures- which included physician notification 4. The nurse managers will continue with the AM Clinical Meeting Monday – Friday i. On Saturday and Sunday a nurse manager will be in the facility each day. ii. Physical rounds will be completed on each unit, every AM, prior to AM Clinical Meeting. A nurse manager will be speaking to the floor nurses regarding any resident change of	

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F 157	Continued From page 7 again on 9/11/14 by the nurse management team (director of nursing, assistant director of nursing, 2 unit managers, wound nurse) a. The audit consisted of reviewing 100% of the nursing notes in the past 24 hours to ensure all residents experiencing any change of condition have had an appropriate nursing assessment and interventions, as indicated; physician notification for further guidance, as indicated and activation of EMS immediately, if indicated. 1. 2 residents were started on an antibiotic with appropriate physician notification 2. 2 resident had a fall with appropriate physician notification 3. 1 hospice resident expired with appropriate physician notification 4. No other concerns were identified 2. On 9/10/14 and 9/11/14, a facility nurse manager has been assigned to each unit observing all facility residents which reside on those units for any concerns and or change in condition. 1. No concerns were identified in regards to MD notification. 3. The MD and/or his nurse practitioner are in the facility Monday - Friday and while in the facility staff will notify them there. When they are not in the facility then they will be contacted through the on-call service. MD notification is documented under the nursing charting in the medical record. 4. The MD is notified immediately in non-life threatening emergencies for further guidance and after EMS is activated in life threatening emergencies. PROCESSES IMPLEMENTED TO PREVENT FURTHER OCCURRENCES 1. In-servicing for the nurses was started on 9/10/14 by the Clinical Resource Nurse and DON.	F 157	conditions and physician notification for further guidance. In addition, the nurse manager will round on any residents which have had an identified change of condition. 5. A nurse manager will review the 24 hour report, alert charting log and nursing notes to ensure all change of conditions have been communicated to the physician, that guidance has been provided and documented in the medical record under the nurse charting tab. 6. **On 9/30/14 a "Quality Assurance Worksheet- Resident Status Change" audit form was implemented. The audit form will be completed by the nurse management team. The audit form includes, but is not limited to, physician notification. The audit form will be used daily by the nurse management team Monday through Friday times 12 weeks, then the nurse managers will use the audit form on 5 random charts weekly times 4 weeks.**	

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F 157	Continued From page 8 At this point 40 nurses out of 52 have been in-serviced. No nurse will be able to work the floor until they are in-serviced. The in-service addressed the following: a. 24 Hour Report b. Alert Charting Process c. Infection Reports d. Change of Condition Guidelines- which included physician notification e. Documentation Guidelines- which included physician notification f. Appropriate assessment, interventions, follow up to interventions g. Emergency Procedures- Seizure Management h. Care of a Resident in Emergency Situations- which included but not limited to- initial assessment (objective and subjective symptoms), head injuries, lacerations, suspected fractures, burns, choking, shortness of breath, chest pain, syncope, seizures, dizziness, diabetic coma/ketoacidosis, insulin shock/insulin reaction, acute psychotic behaviors, ingestion of toxins and physician notification. i. Emergency Procedures- which included physician notification 2. Two nurses were identified in this deficiency. a. One nurse was in-serviced on 9/11/14. b. The other nurse has been suspended at this time pending an abuse allegation of neglect- she was suspended on 9/11/14. 3. The Nurse Managers were in-serviced by the Clinical Resource Nurse on 9/10/14 on the following: a. 24 Hour Report- and how to use them b. Alert Charting Process c. Infection Reports d. Change of Condition Guidelines- which included physician notification	F 157	**Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** 1. During the AM Clinical Meeting all areas listed in #4 will be completed by the Nurse Management Team. a. The Nurse Management Team consists of the DON, ADON, 2 Unit Managers and 2 MDS Coordinators. b. The AM Clinical Meeting is held Monday-Friday at 8:45 AM. c. On Saturday and Sunday a nurse manager will be in the facility each day to complete the areas listed in #4. 2. During the AM Clinical Meeting any discrepancies identified will be documented, investigated and corrected immediately by the Nurse Management Team. 3. From any discrepancies identified further education and/or disciplinary action will occur with the staff member responsible. 4. The Clinical Resource Nurse will	

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F 157	Continued From page 9 e. Documentation Guidelines- which included physician notification f. Appropriate assessment, interventions, follow up to interventions g. Emergency Procedures- Seizure Management h. Care of a Resident in Emergency Situations- which included but not limited to- initial assessment (objective and subjective symptoms), head injuries, lacerations, suspected fractures, burns, choking, shortness of breath, chest pain, syncope, seizures, dizziness, diabetic coma/ketoacidosis, insulin shock/insulin reaction, acute psychotic behaviors, ingestion of toxins and physician notification. i. Emergency Procedures- which included physician notification 4. The nurse managers will continue with the AM Clinical Meeting Monday - Friday a. On Saturday and Sunday a nurse manager will be in the facility each day. b. Physical rounds will be completed on each unit, every AM, prior to AM Clinical Meeting. A nurse manager will be speaking to the floor nurses regarding any resident change of conditions and physician notification for further guidance. In addition, the nurse manager will round on any residents which have had an identified change of condition. c. A nurse manager will review the 24 hour report, alert charting log and nursing notes to ensure all change of conditions have been communicated to the MD, that guidance has been provided and documented in the medical record under the nurse charting tab. MONITORING 1. During the AM Clinical Meeting all areas listed in #2 will be completed by the Nurse	F 157	review the daily audits (labs, nursing notes, BM list, telephone orders) completed by the Nurse Management Team, weekly times 4 weeks, to ensure there is appropriate physician notification and guidance has been provided for any change of condition. 5. If trends or discrepancies are noted this Quality Assurance (QA) process will be revised by the QA committee. 6. As discrepancies and trends are identified through these QA audits further education and training will be provided. 7. The facility will continue to involve the Medical Director in the facility processes in order to seek guidance and support. 8. A member of the Home Office staff will be on-site weekly for at least the next 30 days to offer guidance, support, training and monitoring of this plan. 9. On 8/25/14, **Apex HealthCare Solutions, the managing company for Carver Living Center**, hired a new Clinical Resource Nurse, who will continue to provide guidance, support, training and monitoring to the DON and Nurse Management Team.	

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F 157	Continued From page 10 Management Team. a. The Nurse Management Team consists of the DON, ADON, 2 Unit Managers and 2 MDS Coordinators. b. The AM Clinical Meeting is held Monday-Friday at 8:15 AM. c. On Saturday and Sunday a nurse manager will be in the facility each day to complete the areas listed in #2. 2. During the AM Clinical Meeting any discrepancies identified will be documented, investigated and corrected immediately by the Nurse Management Team. 3. From any discrepancies identified further education or disciplinary action will occur with the staff member responsible. 4. The Clinical Resource Nurse will review the daily audits (labs, nursing notes, BM list, telephone orders) completed by the Nurse Management Team, weekly times 4 weeks, to ensure there is appropriate MD notification and guidance has been provided for any change of condition. 5. If trends or discrepancies are noted this QA process will be revised by the QA committee. 6. As discrepancies and trends are identified through these QA audits further education and training will be provided. 7. The facility will continue to involve the Medical Director in the facility processes in order to seek guidance and support. 8. A member of the Home Office staff will be on-site weekly for at least the next 30 days to offer guidance, support, training and monitoring of this plan. 9. On 8/25/14, Apex hired a new Clinical Resource Nurse, who will continue to provide guidance, support, training and monitoring to the DON and Nurse Management Team.	F 157	**10. The Quality Assurance Committee will review facility progress monthly on the identified concerns.** **11. Facility alleges compliance with this deficiency on 10/15/14.**	

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F 157	Continued From page 11 The facility alleges the immediacy of these discrepancies have been abated on 9/11/14. On 09/11/14 at 6:45 PM, the credible allegation was validated. Staff interviews with licensed nurses revealed the facility had implemented corrective measures which included in-services of licensed nurses regarding proper facility procedure and protocol for residents experiencing seizures, respiratory distress, changes in levels of consciousness (LOC), emergency situations, physician notification, activation of emergency medical services and appropriate resident care during a seizure, respiratory distress, change in LOC or any emergency situation.	F 157	**F 224** **Corrective action for residents found to have been affected by this deficiency:** Resident #186 no longer resides at this facility. **Corrective action for residents that may be affected by this deficiency:** 1. A 100% audit was completed on 9/10/14 and again on 9/11/14 by the nurse management team (director of nursing, assistant director of nursing, 2 unit managers, wound nurse) 2. The audit consisted of reviewing all nursing notes in the past 24 hours to ensure there were no identified concerns of neglect with residents experiencing a change of condition. a. 0 out of a 181 residents had no identified concerns regarding neglect. b. No other concerns were identified regarding ADL cares or change in condition. 3. On 9/10/14 and 9/11/14, a facility nurse manager has been assigned to each unit observing all facility residents which reside on those units for signs and symptoms of neglect related to ADL cares.	
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to provide emergency treatment for grand mal seizures and respiratory distress, including immediate initiation of emergency medical services (EMS) and notification of the physician, for 1 of 3 residents reviewed for neglect (Resident #186).	F 224		

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F 224	Continued From page 12 The Immediate Jeopardy (IJ) began on 8/18/14 at 5:30 am for Resident #186 when the resident was found by the staff in continuous seizures and respiratory distress. The immediate jeopardy was removed on 9/11/14 at 6:45 pm when the facility provided and implemented an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity of [D] (no actual harm with the potential for more than minimal harm) that is not immediate jeopardy to ensure monitoring systems put in place are effective and included in the facility's Quality Assurance Program. Findings included: A review of the facility's procedure policy dated 2006 titled "Seizure, Nursing Management of: Basic responsibility - Licensed Nurse" in part read "If a resident is in bed, remove pillow from under resident's head and gently hyperextend head to maintain airway patency. Position on side, if possible, to facilitate drainage of mucus and decrease possibility of aspiration of secretions." Resident #186 was admitted into the facility on 1/27/12. Diagnoses included Seizures, Anoxic Brain Injury (anoxia occurs when the brain does not receive oxygen for a period of time resulting in loss of brain function).The Minimum Data Set completed on 7/10/14 indicated the resident's cognitive pattern was severely impaired. Extensive assistance was required with bed mobility and transfers. Seizure was indicated. The care plan dated 2/14/14 indicated seizures as a problem. A stated goal read: resident will have airway open. Approaches read: administer meds as ordered, observe for side effects and effectiveness, neuro (neurological) assessment as needed, notify physician as needed, maintain airway, and report seizures.	F 224	a. No concerns were identified in regards to neglect related to activities of daily living (ADL) cares. 4. On 9/11/14 the administrator completed 100% facility rounds to ensure there were no areas of concerns with neglect related to ADL cares. a. No concerns were identified in regards to neglect related to ADL cares. **Measures that will be put into place to ensure that this deficiency does not recur:** 1. In-servicing for the nurses was started on 9/10/14 by the Clinical Resource Nurse and DON. On 9/11/14, 40 nurses out of 52 have been in-serviced. No nurse will be able to work the floor until they are in-serviced. The in-service addressed the following: a. 24 Hour Report b. Alert Charting Process c. Infection Reports d. Change of Condition Guidelines e. Documentation Guidelines f. Appropriate assessment, interventions, follow up	

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F 224	Continued From page 13 A review of the nurses' notes dated 8/14 and 8/17/14 revealed no seizures or respiratory or lung concerns. A review of the physician orders for August 2014 revealed no as needed (prn) seizure medications ordered. Scheduled seizure medications included: · Clonazepam 1 milligram (mg) every eight hours at 6:00 am, 2:00 pm and 10:00 pm. · Lacosamide 200 mg every 12 hours at 6:00 am and 6:00 pm. · Keppra 1000 mg twice daily at 8:00 am and 8:00 pm. On 9/10/14 at 11:51 AM, in an interview, Nurse #1 acknowledged she was resident #186's primary nurse from 7 pm - 7 am. She stated when she entered the room around 5:30 am she observed the resident in respiratory distress, having seizures and in a supine (flat on her back) position. The nurse stated she assessed the resident's vital signs and her pulse oxygen saturation was low at 87 percent (%). She indicated she positioned the resident to a 45 degree upright angle, applied oxygen at 2 liters per minute and gave her a breathing treatment with a Nebulizer. Nurse #1 stated the resident was unresponsive and actively having a seizure. She stated the resident normally has some movements in her extremities but this was non-stop and sounded like she (Resident #186) had a blockage in her throat. Nurse #1 stated there were no secretions observed coming from the resident's mouth, nor did she have to suction. Nurse #1 stated repeated oxygen saturation revealed the oxygen increased to 89 or 90 % and	F 224	to interventions g. Emergency Procedures-Seizure Management h. Care of a Resident in Emergency Situations-which included but not limited to- initial assessment (objective and subjective symptoms), head injuries, lacerations, suspected fractures, burns, choking, shortness of breath, chest pain, syncope, seizures, dizziness, diabetic coma/ketoacidosis, insulin shock/insulin reaction, acute psychotic behaviors, ingestion of toxins and physician notification. i. Emergency Procedures-which included physician notification and resident protection and preventing neglect in an emergency situation (Resident Protection System). **j. On 9/30/14 it was determined that 52 of the 52 nurses have received the in-service.** k. As of 10/1/14 no new	

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F 224	Continued From page 14 she further increased the oxygen flow to 4 liters per minute. Nurse #1 indicated she initiated EMS - she stated she probably initiated EMS after 6:00 am. She stated she did not notify the physician concerning the resident's current status. Nurse #1 stated she called the physician after the resident left the facility by ambulance to the local hospital with EMS. Nurse #1 did not elaborate why she did not immediately call 911. A review of the nurse's noted dated 8/18/14 revealed at 5:30 am, Resident #186 was assessed by Nurse #1 with an oxygen saturation of 87% (normal 95-100%) on room air, blood pressure 92/58, respiratory rate of 25 breaths per minute, wheezing, obvious gurgling, very lethargic/sleepy; difficult to arouse and seizures. A nebulizer treatment (a common treatment for respiratory problems; for example asthma) was administered; oxygen was started at 4 liters per minute, seizure indicated as nonstop and resident status did not improve. Nurse #1 further noted the night nurse (Nurse #2) in the front hall helped her in assessing the resident. Emergency Medical Services was documented as called and the resident was transported to the local hospital via stretcher at 7:30 am. The physician and responsible party were indicated as notified of the resident's transfer to the hospital by Nurse #1. On 9/10/14 at 12:21 pm, in an interview, Nurse #2 stated Nurse #1 came out in the hall and requested her help. She stated it must have been between 6:00 am and 7:00 am because she was making rounds and did not recall the exact time. Nurse #2 indicated she went into Resident #186's room with Nurse #1 and observed the resident lying on the bed; the resident was shaking and having difficulty breathing and coughing a lot. She	F 224	**nurses have been hired in the facility.** **i. Any new nurses hired will receive education regarding the "Resident Protection System (Preventing Abuse and Neglect).** 2. Two nurses were identified in this deficiency. a. One nurse was in-serviced on 9/11/14.- (see bullet points a-i above). b. The other nurse has been suspended at this time pending an abuse allegation of neglect- she was suspended on 9/11/14. **The nurse's employment was terminated on 9/16/14 and the allegation of neglect was substantiated.** a. The other nurse has been suspended at this time pending an abuse allegation of neglect- she was suspended on 9/11/14. **The nurse's employment was terminated on 9/16/14 and the allegation of neglect was substantiated.** 3. The allegation of neglect was reported to the appropriate	

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F 224	Continued From page 15 stated the resident had a blood pressure cuff on her right arm, receiving oxygen by nasal cannula and unresponsive. Nurse #2 indicated they (she and Nurse #1) woke the resident up using a sternal rub (briskly rubbing knuckles over sternum) performed 2 or 3 times and her body continued to shake throughout the sternal rubs. She elaborated the resident opened her eyes but never spoke, eyes were hazy and she was coughing. Nurse #2 said she informed Nurse #1 they needed to activate (call) EMS. Nurse #2 indicated Nurse #1 then left the room and she (Nurse #2) opened the closet, picked out an outfit for the resident, lowered the resident to a flat position on her back, bathed the resident in the flat position on her back and then dressed the resident while in the same position, until she completed the bath and put the resident's shirt and pants on. She further indicated the resident continued with seizures and coughing throughout being bathed and dressed by her. Nurse #2 concluded she was aware the resident was having continued seizures and coughing while she bathed and dressed the resident, however she continued with the tasks because the resident had oxygen on and she wanted the resident to look nice to go to the hospital. A review of the EMS dispatch report for the county emergency services in part read "Was called at 6:53 am on 8/18/14 reporting a resident with seizures, ambulance in route at 6:54 am, the ambulance traveled one mile and arrived at the facility at 6:59 am, emergency crew at bedside 7:05 am. Chief complaint: seizures/convulsion - actively. Seizure duration greater than 5 minutes, seizure type - Grand Mal [for] 1 hour." The EMS report further read "Vital signs on scene on 8/18/14 at 7:09 am temperature 97.4, pulse 84,	F 224	state agencies on 9/11/14. **The 5 day investigation was completed, substantiated and filed with the North Carolina Department of Health and Human Services on 9/16/14.** 4. The resident is protected as they no longer reside in the facility. 5. The facility administrator will follow the abuse protocol and complete the investigation as outlined in the policy and procedures and per federal regulations. 6. The Nurse Managers were in-serviced by the Clinical Resource Nurse on 9/10/14 on the following: a. 24 Hour Report- and how to use them b. Alert Charting Process c. Infection Reports d. Change of Condition Guidelines- which included physician notification e. Documentation Guidelines- which included physician notification f. Appropriate assessment, interventions, follow up to interventions g. Emergency Procedures- Seizure Management	

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F 224	Continued From page 16 respirations 20, lung sounds left wheeze/rhonchi (abnormal lung sounds), lung sounds right wheezes/ rhonchi. Rhonchi is described by Taber's as "A wheezing, snoring, or squeaking sound heard during auscultation (listening to chest with stethoscope) of a person with partial airway obstruction. Mucus or other secretion in the airway, bronchial hyperactivity that occlude respiratory passages." A review of the summary statement from the EMS report read "Dispatched by 911 to a seizure. Arrived to find Resident #186 actively seizing. Patient assessed as charted. Patient found in care of staff at local skilled facility with active seizure activity noted. Staff state patient with hx (history) of same secondary to cardiac arrest and anoxic brain injury. Patient began seizing at approx (approximately) 5:30 this morning. IV (intravenous) access established x 1 attempt (by EMS) as charted and IV Versed administered per protocol. Versed is a Benzodiazepine used for status epilepticus, a continuous seizure activity without a pause. Seizure activity reduced however some residual focal activity remained. Patient continued on oxygen at 10 liters per minute. During transport, second dose of IV Versed administered due to continued seizure activity. Seizure activity never full ceased during EMS care and/or transport." A review of the hospital record dated 8/18/14 in part read, "The patient presented in status epilepticus. She required intubation (insertion of a tube into the trachea or windpipe to keep open or restore patency if obstructed) for airway protection and aspiration pneumonia and was admitted into to the ICU (intensive care unit). She was placed on a Versed gtt (drip), her Keppra	F 224	h. Care of a Resident in Emergency Situations- which included but not limited to- initial assessment (objective and subjective symptoms), head injuries, lacerations, suspected fractures, burns, choking, shortness of breath, chest pain, syncope, seizures, dizziness, diabetic coma/ketoacidosis, insulin shock/insulin reaction, acute psychotic behaviors, ingestion of toxins and physician notification. i. Emergency Procedures- which included physician notification and resident protection and preventing neglect in an emergency situation (Resident Protection System). 7. The nurse managers will continue with the AM Clinical Meeting Monday – Friday a. On Saturday and Sunday a nurse manager will be in the facility each day. b. Physical rounds will be	

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F 224	Continued From page 17 (seizure prevention medication) was increased and she was Dilantin (anticonvulsant medication) loaded. Her EEG (electroencephalogram, to view brain waves) indicated an underlying seizure disorder. She was felt to be having breakthrough seizures due to infection and thought to have septic shock due to aspiration pneumonia, which required volume resuscitation with intravenous fluids." Resident #186 was discharged from the hospital on 8/30/14 to another skilled nursing facility. On 9/10/14 at 2:13 pm, in an interview, the Director of Nursing stated if a resident was observed having a seizure she expected the nursing staff to position the resident in an upright position to protect the airway with the resident rolled toward the left side and call EMS immediately if the seizure lasted more than 15 minutes. The DON stated Resident #186 was experiencing a medical emergency and laying the resident flat on her back and bathing her was inappropriate considering the resident's physical condition. On 9/10/14 at 12:52 pm, in an interview, the physician (medical director) stated if a resident was having a seizure that lasted longer than 10-15 minutes, he expected the resident to be transported to the hospital immediately by EMS and to be notified immediately afterwards. The physician indicated if a resident was having an active seizure he did not expect the resident to be positioned in a flat supine (positioned on back) position because the resident would be at risk for respiratory aspiration. He concluded he recalled being made aware by the facility the resident was transported to the hospital; however he did not know the exact time he was called.	F 224	completed on each unit, every AM, prior to AM Clinical Meeting. A nurse manager will be speaking to the floor nurses regarding any resident change of conditions, ADL cares, neglect and physician notification for further guidance. In addition, the nurse manager will round on any residents which have had an identified change of condition to ensure there are no concerns with ADL cares. c. A nurse manager will review the 24 hour report, alert charting log and nursing notes to ensure all change of conditions have been communicated to the physician, that guidance has been provided and documented in the medical record under the nurse charting tab. 8. On 9/30/14 a "Quality Assurance Worksheet- Resident Status Change" audit form was implemented. The audit form	

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F 224	Continued From page 18 The Administrator and the Director of Nursing were notified of the immediate jeopardy on 9/11/14 at 10:45 am. The immediate jeopardy was removed on 9/11/14 at 6:45 pm when the facility provided an acceptable credible allegation that in part read: "Credible Allegation of Compliance: RESIDENT AT RISK 1. Resident #186 no longer resides at this facility. IDENTIFYING OTHER RESIDENTS AT RISK 1. A 100% audit was completed on 9/10/14 and again on 9/11/14 by the nurse management team (director of nursing, assistant director of nursing, 2 unit managers, wound nurse) 2. The audit consisted of reviewing all nursing notes in the past 24 hours to ensure there were no identified concerns of neglect with residents experiencing a change of condition. a. 0 out of a 181 residents had no identified concerns regarding neglect. b. No other concerns were identified. 3. On 9/10/14 and 9/11/14, a facility nurse manager has been assigned to each unit observing all facility residents which reside on those for signs and symptoms of neglect related to ADL (Activities of Daily Living) cares. a. No concerns were identified in regards to neglect related to activities of daily living (ADL) cares. 4. On 9/11/14 the administrator completed 100% facility rounds to ensure there were no areas of concerns with neglect related to ADL cares. a. No concerns were identified in regards to	F 224	will be completed by the nurse management team. The audit form includes, but is not limited to, ensuring that the status change was not related to staff performance and if it was, has possible neglect been reported through the "Resident Protection System". The audit form will be used daily by the nurse management team Monday through Friday times 12 weeks, then the nurse managers will use the audit form on 5 random charts weekly times 4 weeks. 9. On 9/17/14 and 9/18/14 in-servicing for all facility staff (which included but not limited to nurses, nurse aides and certified nursing assistants) was started on the following: a. Resident Protection System- Preventing Abuse and Neglect b. Observation of Resident and Reporting Important Information About Their Care, Condition or Behavior c. What to Observe and Report d. When to Report e. Who to Report to 10. On 9/30/14 it was determined	

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F 224	Continued From page 19 neglect related to ADL cares. PROCESSES IMPLEMENTED TO PREVENT FURTHER OCCURRENCE 1. In-servicing for the nurses was started on 9/10/14 by the Clinical Resource Nurse and DON. At this point 40 nurses out of 52 have been in-serviced. No nurse will be able to work the floor until they are in-serviced. The in-service addressed the following: a. 24 Hour Report b. Alert Charting Process c. Change of Condition Guidelines d. Documentation Guidelines e. Appropriate assessment, interventions, follow up to interventions f. Emergency Procedures- Seizure Management g. Care of a Resident in Emergency Situations- which included but not limited to- initial assessment (objective and subjective symptoms), head injuries, lacerations, suspected fractures, burns, choking, shortness of breath, chest pain, syncope, seizures, dizziness, diabetic coma/ketoacidosis, insulin shock/insulin reaction, acute psychotic behaviors, ingestion of toxins and physician notification. h. Emergency Procedures 2. Two nurses were identified in this deficiency. a. One nurse was in-serviced on 9/11/14.- (see bullet points a-h above) b. The other nurse has been suspended at this time pending an abuse allegation of neglect- she was suspended on 9/11/14. i. The allegation of neglect was reported to the appropriate state agencies on 9/11/14. ii. The resident is protected as they no longer reside in the facility. iii. The facility administrator will follow the abuse	F 224	**that all employees except one have received this in-service. This employee will not be allowed to return to work until the in-servicing is completed.** **11. Any new employees hired will receive education regarding the "Resident Protection System (Preventing Abuse and Neglect) upon hire and twice a year.** **<u>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</u>** 1. During the AM Clinical Meeting all areas listed in #4 will be completed by the Nurse Management Team. a. The Nurse Management Team consists of the DON, ADON, 2 Unit Managers and 2 MDS Coordinators. b. The AM Clinical Meeting is held Monday-Friday at 8:45 AM. c. On Saturday and Sunday a nurse manager will be in the facility each day to complete the areas listed in #7.	

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F 224	Continued From page 20 protocol and complete the investigation as outlined in the policy and procedures and per federal regulations. 3. The Nurse Managers were in-serviced by the Clinical Resource Nurse on 9/10/14 on the following: a. 24 Hour Report- and how to use them b. Alert Charting Process c. Infection Reports d. Change of Condition Guidelines- which included physician notification e. Documentation Guidelines- which included physician notification f. Appropriate assessment, interventions, follow up to interventions g. Emergency Procedures- Seizure Management h. Care of a Resident in Emergency Situations- which included but not limited to- initial assessment (objective and subjective symptoms), head injuries, lacerations, suspected fractures, burns, choking, shortness of breath, chest pain, syncope, seizures, dizziness, diabetic coma/ketoacidosis, insulin shock/insulin reaction, acute psychotic behaviors, ingestion of toxins and physician notification. I. Emergency Procedures- which included physician notification 4. The nurse managers will continue with the AM Clinical Meeting Monday - Friday a. On Saturday and Sunday a nurse manager will be in the facility each day. b. Physical rounds will be completed on each unit, every AM, prior to AM Clinical Meeting. A nurse manager will be speaking to the floor nurses regarding any resident change of conditions and physician notification for further guidance. In addition, the nurse manager will round on any residents which have had an	F 224	2. During the AM Clinical Meeting any discrepancies identified will be documented, investigated and corrected immediately by the Nurse Management Team. 3. From any discrepancies identified further education or disciplinary action will occur with the staff member responsible. 4. The Clinical Resource Nurse will review the daily audits (labs, nursing notes, BM list, telephone orders) completed by the Nurse Management Team, weekly times 4 weeks, to ensure there is appropriate physician notification and guidance has been provided for any change of condition. 5. If trends or discrepancies are noted this QA process will be revised by the QA committee. 6. As discrepancies and trends are identified through these QA audits further education and training will be provided. 7. The facility will continue to involve the Medical Director in the facility processes in order to seek guidance and support. 8. A member of the Home Office staff will be on-site weekly for at least the next 30 days to offer guidance, support, training and monitoring of this plan.	

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F 224	Continued From page 21 identified change of condition to ensure there are no concerns with ADL cares. c. A nurse manager will review the 24 hour report, alert charting log and nursing notes to ensure all change of conditions have been communicated to the MD, that guidance has been provided and documented in the medical record under the nurse charting tab. The facility alleges the immediacy of these discrepancies have been abated on 9/11/14." On 9/11/14 at 6:45 pm, the credible allegation was validated. Staff interviews with licensed nurses revealed the facility had implemented corrective measures which included in-services of licensed nurses regarding proper facility procedure and protocol for residents' experiencing seizures, respiratory distress, changes in levels of consciousness (LOC), emergency situations, physician notification, activation of emergency medical services and appropriate resident care during a seizure, respiratory distress, change in LOC or any emergency situation.	F 224	9. On 8/25/14, **Apex HealthCare Solutions, the managing company for Carver Living Center,** hired a new Clinical Resource Nurse, who will continue to provide guidance, support, training and monitoring to the DON and Nurse Management Team. 10. **The Quality Assurance Committee will review facility progress monthly on the identified concerns.** 11. **Facility alleges compliance with this deficiency on 10/15/14.**	
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	F 309		

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F 309	Continued From page 22 by: Based on record review, emergency medical services (EMS) report, and staff and physician interviews, the facility failed to provide emergency treatment for seizures and respiratory distress, including immediate initiation of emergency medical services and notification of physician, for 1 of 3 residents reviewed for wellbeing (Resident #186). The Immediate Jeopardy (IJ) began on 08/18/14 at 5:30 AM for Resident #186 when resident was found by staff in continuous seizures and respiratory distress. The Administrator was notified of the Immediate Jeopardy on 9/11/14 at 10:45 AM. The Immediate Jeopardy was removed on 09/11/14 at 6:45 PM when the facility demonstrated it had implemented a credible allegation. The facility was left out of compliance at no actual harm with potential for more than minimal harm that is not immediate jeopardy [D] so that the facility can complete all staff in-services and monitoring systems could be implemented and included in the Quality Assurance Program. Findings included: Resident #186 was admitted to the facility on 01/27/12 with cumulative diagnoses of seizure disorder due to anoxic brain damage. A review of resident's physician order sheet for September 2014 revealed orders for Keppra, Vimpat, and Klonopin. Keppra is an anticonvulsant, Vimpat is an anticonvulsant and Klonopin is medication with anticonvulsant properties.	F 309	**F 309** **Corrective action for residents found to have been affected by this deficiency:** Resident #186 no longer resides at this facility. **Corrective action for residents that may be affected by this deficiency:** 1. A 100% audit was completed on 9/10/14 and again on 9/11/14 by the nurse management team (director of nursing, assistant director of nursing, 2 unit managers, wound nurse) a. The audit consisted of reviewing 100% of the nursing notes in the past 24 hours to ensure all residents experiencing any change of condition have had an appropriate nursing assessment and interventions, as indicated; physician notification for further guidance, as indicated and activation of EMS immediately, if indicated. i. 2 residents were started on an antibiotic with	

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F 309	Continued From page 23 A review of the quarterly Minimum Data Set (MDS) dated 07/10/14 indicated the resident was severely cognitively impaired. Care plan dated 02/14/14 indicated seizures as problem. Goal: resident will have airway open. Approaches: administer meds as ordered, observe for side effects and effectiveness, neuro (neurological) assessment as needed, notify MD as needed, maintain airway, and report seizures. On 09/10/14 at 5:45 PM, an interview was conducted with Nurse Aide (NA #1) who took care of the resident on 8/18/14 (third shift 11PM to 7AM). She stated the resident was fine during the night. "I went into the room on rounds about 5:30 AM and she was breathing hard." NA#1 indicated when she discovered the resident, she was having trouble breathing and jerking movements. NA #1 stated she went to get Nurse #1. In an interview with Nurse #1 on 09/10/14 at 11:51 AM, she stated she knew Resident #186 and had taken care of her prior to 08/18/14. She stated when she entered the room around 5:30 AM she observed the resident in respiratory distress and having seizures. The resident was in a supine (flat on her back) position. The nurse stated she took the resident's vital signs and her pulse oxygen saturation was low at 87 percent. She moved the resident to a 45 degree angle, and applied oxygen at 2 liters per minute. Nurse #1 stated "I gave her a breathing treatment with a Nebulizer." Nurse #1 stated the resident was unresponsive and actively having a continuous seizure. She stated the resident normally had some movements in her extremities but this was non-stop movements. Nurse #1 stated it	F 309	appropriate assessment, intervention and physician notification ii. 2 residents had a fall with appropriate assessment, intervention and physician notification iii. 1 hospice resident expired with appropriate assessments, intervention and physician notification iv. No other concerns were identified regarding shortness of breath, seizures and change in level of consciousness. 2. On 9/10/14 and 9/11/14, a facility nurse manager has been assigned to each unit observing all facility residents which reside on those units for any concerns and/or change in condition.	

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F 309	Continued From page 24 sounded like she had a blockage in her throat. She stated there were no secretions coming from her mouth. She stated she did not attempt to suction the resident. Nurse #1 stated when a repeat oxygen saturation was done, the oxygen was up to 89 or 90 percent and she increased the oxygen flow to 4 liters per minute. Nurse #1 stated she did not call the resident's physician to report the seizure or see if oxygen should be increased at that time. Nurse #1 stated she called Emergency Medical Service (EMS) and stated probably sometime after 6 AM. Nurse #1 stated she did not call the physician at that time. She stated she called the physician and responsible party after the resident had left the facility with EMS at 8:14 AM. In nursing notes for 08/18/14 at 8:14 AM Nurse #1 documented, "Blood pressure 92/58 at 5:30 AM, pulse (rate) 64, temperature 98.2, respiratory rate 25 (breaths per minute), O2 (oxygen saturation) 87% on room air at 5:30 AM. Comments: Resident was wheezing, obvious gurgling, very lethargic/sleepy; difficult to arouse, has seizures. Nebulizer treatment given, O2 (oxygen) started at 4L/minute (Liters per minute). Seizure was non-stop and resident status did not improve. The Night Nurse in the front hall also helped in assessing the resident. EMS was called and resident was transported to [local hospital] via stretcher at 7:30 AM. Dr. [attending physician] notified; resident's daughter notified of resident's transfer". In an interview with Nurse #2 on 09/10/14 at 12:21 PM, she stated that on 08/18/14 between 6:00 AM to 7:00 AM Nurse #1 came out in the hall to request help with Resident #186. She stated it must have been between 6 and 7 AM;	F 309	a. No concerns were identified in regards to physician notification or failure to identify a resident's change of condition related to shortness of breath, seizures and change in level of consciousness. b. The physician and/or his nurse practitioner are in the facility Monday – Friday and while in the facility staff will notify them there. When they are not in the facility then they will be contacted through the on-call service. Physician notification is documented under the nursing charting in the medical record. c. If the MD or NP is on-site they will immediately be called to the resident's room if a change of condition related to shortness of breath, seizures and change in level of consciousness is noted. 3. The physician is notified immediately in non-life threatening emergencies for	

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F 309	Continued From page 25 she did not recall the exact time. Nurse #2 stated she went into Resident #186's room with Nurse #1 and observed the resident lying on the bed; she was shaking and having difficulty breathing. The resident had a blood pressure cuff on her right arm, and was getting oxygen via nasal cannula and was unresponsive. Nurse #2 stated "We woke her up using a sternal rub. She opened her eyes but never spoke. Her eyes were hazy and she was coughing." Nurse #2 stated she repeated the sternal rub. She stated the resident's body continued to shake during sternal rubs. Nurse #2 stated that she told Nurse #1 that they needed to call EMS. Nurse #2 stated Nurse #1 left the room to call EMS and prepare the discharge paperwork and she stayed in the room with the resident. She stated "I opened the closet and picked out an outfit for the resident. Then I washed her up and dressed her. I had to lay her down to get her shirt and pants on." Nurse #2 stated the resident was seizing and unresponsive while being bathed and dressed. Nurse #2 stated she was aware the resident was having continued seizures throughout the bath and dressing, however she continued on with the tasks because she wanted the resident to look nice to go to the hospital. Review of Resident #186's 08/18/14 Emergency Medical Service (EMS) report revealed Dispatch for the County services " was called at 6:53 AM on 08/18/14 reporting a resident with seizures, ambulance in route at 6:54 AM, the ambulance traveled one mile and arrived at the facility on 6:59 AM, emergency crew at bedside 7:05 AM. Chief Complaint, Seizures/Convulsion, Actively. Seizure duration greater than 5 minutes, seizure type- Grand Mal [for] 1 hour." (Taber's Medical Dictionary, 19th edition, describes Grand Mal as	F 309	further guidance and after EMS is activated in life threatening emergencies. **Measures that will be put into place to ensure that this deficiency does not recur:** 1. In-servicing for the nurses was started on 9/10/14 by the Clinical Resource Nurse and DON. On 9/11/14, 40 nurses out of 52 have been in-serviced. No nurse will be able to work the floor until they are in-serviced. The in-service addressed the following: a. 24 Hour Report b. Alert Charting Process c. Infection Reports d. Change of Condition Guidelines- which included physician notification e. Documentation Guidelines- which included physician notification f. Appropriate assessment, interventions, follow up to interventions g. Emergency Procedures- Seizure Management h. Care of a Resident in Emergency Situations- which included but not limited to- initial	

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F 309	Continued From page 26 epilepsy, loss of consciousness with violent movements of the extremities). The report continued, "lung sounds Left Wheeze/Rhonchi, and lung sounds right wheezes/ Rhonchi." [Rhonchi are described by Taber's as "A wheezing, snoring, or squeaking sound heard during auscultation (listening to chest with stethoscope) of a person with partial airway obstruction. Mucus or other secretion in the airway, bronchial hyperactivity that occlude respiratory passages."] Summary statement from EMS read: "Dispatched by 911 to a seizure. Arrived to find a 51 year old female actively seizing. Patient assessed as charted. Patient found in care of staff at local skilled facility with active seizure activity noted. Staff stated patient with hx (history) of same secondary to cardiac arrest and anoxic brain injury. Patient began seizing at approx (approximately) 5:30 this morning. IV (intravenous) access established x 1 attempt as charted and IV Versed administered per protocol. "[Versed is a benzodiazepine used for status epilepticus, a continuous seizure activity without a pause.]" Seizure activity reduced however some residual focal activity remained. Patient continued on O2 at 10 liters per minute. During transport, second dose of IV Versed administered due to continued seizure activity. Seizure activity never fully ceased during EMS care and/or transport." Review of Resident #186's hospital records on 08/18/14 in part read, "The patient presented in status epilepticus. She required intubation for airway protection and admission to the ICU (intensive care unit). She was placed on a Versed gtt (drip), her Keppra was increased and	F 309	assessment (objective and subjective symptoms), head injuries, lacerations, suspected fractures, burns, choking, shortness of breath, chest pain, syncope, seizures, dizziness, diabetic coma/ketoacidosis, insulin shock/insulin reaction, acute psychotic behaviors, ingestion of toxins and physician notification. i. Emergency Procedures- which included physician notification **j. On 9/30/14 it was determined that 52 of the 52 nurses have received the in-service.** **k. As of 10/1/14 no new nurses have been hired in the facility.** **l. Any new nurses hired will receive education on emergency treatment, initiation of emergency medical services and physician notification during the orientation process.** 2. Two nurses were identified in this deficiency.	

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F 309	Continued From page 27 she was Dilantin (another anticonvulsant) loaded. Her EEG (electroencephalogram, to view brain waves) indicated an underlying seizure disorder. She was felt to be having breakthrough seizures due to infection (aspiration pneumonia)". Patient was also suffering from septic shock due to possible aspiration pneumonia. Interview with the Director of Nursing (DON) on 09/10/14 at 2:13 PM, revealed that her expectation was if nursing staff observed a resident seizing that the resident should be raised to an upright position to protect airway, rolled toward the left side, and the nurse should call EMS if the seizure lasted more than 15 minutes. The DON stated Resident #186 was experiencing a medical emergency on 08/18/14 and laying the resident flat on her back for bathing and dressing the resident was inappropriate. The DON revealed the event was discussed on 08/19/14 at the morning meeting. She stated she saw the two hour time frame on the nurses' notes but was not concerned because sometimes it takes EMS time to stabilize a resident. She stated she thought the 'gurgling' was due to seizure activity. In an interview with the Medical Director on 09/10/14 at 12:52 PM, he acknowledged he was called by the nurse on 08/18/14 after the resident left for the hospital. He stated he would have expected to have been called by staff if the resident, with a history of seizures, had a seizure that lasted more than 5-10 minutes and EMS should be initiated immediately. The Administrator was notified of the Immediate Jeopardy on 9/11/14 at 10:45 AM. The facility provided the following credible allegation of compliance:	F 309	a. One nurse was in-serviced on 9/11/14- (see bullet points a-i above). b. The other nurse has been suspended at this time pending an abuse allegation of neglect- she was suspended on 9/11/14. **The nurse's employment was terminated on 9/16/14 and the allegation of neglect was substantiated.** 3. The Nurse Managers were in-serviced by the Clinical Resource Nurse on 9/10/14 on the following: a. 24 Hour Report- and how to use them b. Alert Charting Process c. Infection Reports d. Change of Condition Guidelines- which included physician notification e. Documentation Guidelines- which included physician notification f. Appropriate assessment, interventions, follow up to interventions g. Emergency Procedures- Seizure Management h. Care of a Resident in	

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F 309	Continued From page 28 RESIDENT IDENTIFIED 1. Resident #186 no longer resides at this facility. IDENTIFYING OTHER RESIDENTS AT RISK 1. A 100% audit was completed on 9/10/14 and again on 9/11/14 by the nurse management team (director of nursing, assistant director of nursing, 2 unit managers, wound nurse) a. The audit consisted of reviewing 100% of the nursing notes in the past 24 hours to ensure all residents experiencing any change of condition have had an appropriate nursing assessment and interventions, as indicated; physician notification for further guidance, as indicated and activation of EMS immediately, if indicated. 1. 2 residents were started on an antibiotic with appropriate assessment, intervention and physician notification 2. 2 resident had a fall with appropriate assessment, intervention and physician notification 3. 1 hospice resident expired with appropriate assessments, intervention and physician notification 4. No other concerns were identified regarding shortness of breath, seizures and change in level of consciousness. 2. On 9/10/14 and 9/11/14, a facility nurse manager has been assigned to each unit observing all facility residents which reside on those units for any concerns and or change in condition. 1. No concerns were identified in regards to MD notification or failure to identify a resident's change of condition related to shortness of breath, seizures and change in level of consciousness.	F 309	Emergency Situations- which included but not limited to- initial assessment (objective and subjective symptoms), head injuries, lacerations, suspected fractures, burns, choking, shortness of breath, chest pain, syncope, seizures, dizziness, diabetic coma/ketoacidosis, insulin shock/insulin reaction, acute psychotic behaviors, ingestion of toxins and physician notification. i. Emergency Procedures- which included physician notification 4. The nurse managers will continue with the AM Clinical Meeting Monday – Friday a. On Saturday and Sunday a nurse manager will be in the facility each day. b. Physical rounds will be completed on each unit, every AM, prior to AM Clinical Meeting. A nurse manager will be speaking to the floor nurses regarding any	

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F 309	Continued From page 29 3. The MD and/or his nurse practitioner are in the facility Monday - Friday and while in the facility staff will notify them there. When they are not in the facility then they will be contacted through the on-call service. MD notification is documented under the nursing charting in the medical record. a. If the MD or NP is on-site they will immediately be called to the resident's room if a change of condition related to shortness of breath, seizures and change in level of consciousness is noted. 4. The MD is notified immediately in non-life threatening emergencies for further guidance and after EMS is activated in life threatening emergencies. PROCESSES IMPLEMENTED TO PREVENT FURTHER OCCURRENCES 1. In-servicing for the nurses was started on 9/10/14 by the Clinical Resource Nurse and DON. At this point 40 nurses out of 52 have been in-serviced. No nurse will be able to work the floor until they are in-serviced. The in-service addressed the following: a. 24 Hour Report b. Alert Charting Process c. Change of Condition Guidelines- which included physician notification d. Documentation Guidelines- which included physician notification e. Appropriate assessment, interventions, follow up to interventions f. Emergency Procedures- Seizure Management g. Care of a Resident in Emergency Situations- which included but not limited to- initial assessment (objective and subjective symptoms), head injuries, lacerations, suspected fractures, burns, choking, shortness of breath, chest pain,	F 309	resident change of conditions and physician notification for further guidance. In addition, the nurse manager will round on any residents which have had an identified change of condition. c. A nurse manager will review the 24 hour report, alert charting log and nursing notes to ensure all change of conditions have been communicated to the physician, that guidance has been provided and documented in the medical record under the nurse charting tab. **5. On 9/30/14 a "Quality Assurance Worksheet- Resident Status Change" audit form was implemented. The audit form will be completed by the nurse management team. The audit form includes, but is not limited to, ensuring immediate activation of emergency medical services, appropriate nursing interventions while awaiting the arrival of emergency medical services, immediate physician**	

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F 309	Continued From page 30 syncope, seizures, dizziness, diabetic coma/ketoacidosis, insulin shock/insulin reaction, acute psychotic behaviors, ingestion of toxins and physician notification. h. Emergency Procedures- which included physician notification 2. Two nurses were identified in this deficiency. a. One nurse was in-serviced on 9/11/14.- (see bullet points a-h above) b. The other nurse has been suspended at this time pending an abuse allegation of neglect- she was suspended on 9/11/14. 3. The Nurse Managers were in-serviced by the Clinical Resource Nurse on 9/10/14 on the following: a. 24 Hour Report- and how to use them b. Alert Charting Process c. Infection Reports d. Change of Condition Guidelines- which included physician notification e. Documentation Guidelines- which included physician notification f. Appropriate assessment, interventions, follow up to interventions g. Emergency Procedures- Seizure Management h. Care of a Resident in Emergency Situations- which included but not limited to- initial assessment (objective and subjective symptoms), head injuries, lacerations, suspected fractures, burns, choking, shortness of breath, chest pain, syncope, seizures, dizziness, diabetic coma/ketoacidosis, insulin shock/insulin reaction, acute psychotic behaviors, ingestion of toxins and physician notification. i. Emergency Procedures- which included physician notification 4. The nurse managers will continue with the AM Clinical Meeting Monday - Friday	F 309	notification and documentation of the change of condition in the medical record. The audit form will be used daily by the nurse management team Monday through Friday times 12 weeks, then the nurse managers will use the audit form on 5 random charts weekly times 4 weeks. 6. On 9/17/14 and 9/18/14 in-servicing for all facility staff (which included but not limited to nurses, nurse aides and certified nursing assistants) was started on the following: a. Resident Protection System- Preventing Abuse and Neglect b. Observation of Resident and Reporting Important Information About Their Care, Condition or Behavior c. What to Observe and Report d. When to Report e. Who to Report to f. Quality assessment and Assurance. i. On 9/30/14 it was determined that all employees	

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F 309	Continued From page 31 a. On Saturday and Sunday a nurse manager will be in the facility each day. b. Physical rounds will be completed on each unit, every AM, prior to AM Clinical Meeting. A nurse manager will be speaking to the floor nurses regarding any resident change of conditions and physician notification for further guidance. In addition, the nurse manager will round on any residents which have had an identified change of condition. c. A nurse manager will review the 24 hour report, alert charting log and nursing notes to ensure all change of conditions have been communicated to the MD, that guidance has been provided and documented in the medical record under the nurse charting tab. MONITORING 1. During the AM Clinical Meeting all areas listed in #2 will be completed by the Nurse Management Team. a. The Nurse Management Team consists of the DON, ADON, 2 Unit Managers and 2 MDS Coordinators. b. The AM Clinical Meeting is held Monday-Friday at 8:15 AM. c. On Saturday and Sunday a nurse manager will be in the facility each day to complete the areas listed in #2. 2. During the AM Clinical Meeting any discrepancies identified will be documented, investigated and corrected immediately by the Nurse Management Team. 3. From any discrepancies identified further education or disciplinary action will occur with the staff member responsible. 4. The Clinical Resource Nurse will review the daily audits (labs, nursing notes, BM list, telephone orders) completed by the Nurse	F 309	except one have received this in-service. This employee will not be allowed to return to work until the in-servicing is completed. ii. Any new employees hired will receive education regarding the items listed in 6 a-f during the orientation process. 7. By 10/15/14 all nurses, nurse aides and certified nursing assistants will receive the directed in-service training for citations at 483.25 (a) and (h) (1-2) that involves transfer, ambulation and accidents or falls involving mobility problems by viewing the DVD which has been approved by The Division of Health Services Regulation. 8. On 10/15/14 a directed in-service will be completed for nurses, nurse aides and	

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F 309	Continued From page 32 Management Team, weekly times 4 weeks, to ensure there is appropriate MD notification and guidance has been provided for any change of condition. 5. If trends or discrepancies are noted this QA process will be revised by the QA committee. 6. As discrepancies and trends are identified through these QA audits further education and training will be provided. 7. The facility will continue to involve the Medical Director in the facility processes in order to seek guidance and support. 8. A member of the Home Office staff will be on-site weekly for at least the next 30 days to offer guidance, support, training and monitoring of this plan. 9. On 8/25/14, Apex hired a new Clinical Resource Nurse, who will continue to provide guidance, support, training and monitoring to the DON and Nurse Management Team. The facility alleges the immediacy of these discrepancies have been abated on 9/11/14. On 09/11/14 at 6:45 PM, the credible allegation was validated. Staff interviews with licensed nurses revealed the facility had implemented corrective measures which included in-services of licensed nurses regarding proper facility procedure and protocol for residents experiencing seizures, respiratory distress, changes in levels of consciousness (LOC), emergency situations, physician notification, activation of emergency medical services and appropriate resident care during a seizure, respiratory distress, change in LOC or any emergency situation.	F 309	**certified nursing assistants on identifying change in condition that requires emergency medical treatment and services. This directed in-service will be completed by a North Carolina Board Certified Internal Medicine Physician, with no affiliation to Carver Living Center or Apex HealthCare Solutions.** **<u>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</u>** 1. During the AM Clinical Meeting all areas listed in #4 will be completed by the Nurse Management Team. a. The Nurse Management Team consists of the DON, ADON, 2 Unit Managers and 2 MDS Coordinators. b. The AM Clinical Meeting is held Monday-Friday at 8:45 AM. c. On Saturday and Sunday a nurse manager will be in the facility each day to complete the areas	
F 520 SS=J	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET	F 520		

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F 520	Continued From page 33 QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the facility put in place in July 2014. This was for two federal deficiencies which were originally cited in July of 2014 on a Recertification survey and recited on a current Recertification revisit, complaint survey of September 11, 2014. The deficiencies were recited in the areas of Care &	F 520	listed in #4. 2. During the AM Clinical Meeting any discrepancies identified will be documented, investigated and corrected immediately by the Nurse Management Team. 3. From any discrepancies identified further education or disciplinary action will occur with the staff member responsible. 4. The Clinical Resource Nurse will review the daily audits (labs, nursing notes, BM list, telephone orders) completed by the Nurse Management Team, weekly times 4 weeks, to ensure there is appropriate MD notification and guidance has been provided for any change of condition. 5. If trends or discrepancies are noted this QA process will be revised by the QA committee. 6. As discrepancies and trends are identified through these QA audits further education and training will be provided. 7. The facility will continue to involve the Medical Director in the facility processes in order to seek guidance and support. 8. A member of the Home Office staff will be on-site weekly for at least the next 30 days to offer guidance, support, training and	

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F 520	Continued From page 34 Services and Physician notification. The continued failures of the facility during a Recertification revisit, complaint survey of records show the facility's inability to sustain an effective Quality Assurance program. The Immediate Jeopardy (IJ) began on 8/18/14 at 5:30 am for Resident #186 when the resident was found by the staff in continuous seizures and respiratory distress. The immediate jeopardy was removed on 9/11/14 at 6:45 pm when the facility provided and implemented an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity of [D] (no actual harm with the potential for more than minimal harm) that is not immediate jeopardy to ensure monitoring systems put in place are effective and included in the facility's Quality Assurance Program. Findings included: This tag is cross referenced to: 1a. F 309: Care and Services - During the Recertification survey of July 2014 the facility was cited: Based on record review, staff, physician and nurse practitioner interviews, the facility failed to manage the care of a resident by failure to obtain or recheck a stool sample as ordered by the physician for persistent diarrhea, that resulted in a 17 day delay in medical treatment because the physician was not notified. As a result of continued loose stools, the resident experienced low blood pressures and a fluid volume deficit (loss of bodily fluids), which lead to a low potassium level. The facility also failed to administer potassium as ordered by the physician for a critical potassium level of 2.3 (3.5 - 5.3 reference range) for 1 of 2 residents records reviewed for Clostridium Difficile (Resident #263).	F 520	monitoring of this plan. 9. On 8/25/14, **Apex HealthCare Solutions, the managing company for Carver Living Center,** hired a new Clinical Resource Nurse, who will continue to provide guidance, support, training and monitoring to the DON and Nurse Management Team. **10. The Quality Assurance Committee will review facility progress monthly on the identified concerns.** **11. Facility alleges compliance with this deficiency on 10/15/14.**	

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F 520	Continued From page 35 The facility on September 11, 2014 during a Recertification revisit, complaint survey was recited for F 309 for failure to provide emergency treatment for seizures and respiratory distress, including immediate initiation of emergency medical services and notification of the physician for 1 of 3 residents reviewed for wellbeing (Resident #186) - see F 309 per the CMS-2567 for investigation details. F 309 was originally cited during the July 17, 2014 recertification survey as indicated above in 1a. b. F 157: Physician Notification of Changes - During the Recertification survey of July 2014 the facility was cited: Based on record review, staff, physician and nurse practitioner interviews, the facility failed to notify or consult with the physician or nurse practitioner that a resident had persistent loose stools which resulted in a 17 day delay in medical treatment for 1 of 2 residents reviewed for Clostridium Difficile and failed to notify the physician of missed doses of potassium for 1 of 1 resident with a critical potassium level of 2.3 (Resident #263). The facility on September 11, 2014 during a Recertification revisit, complaint survey was recited F 157 for failure to immediately notify the resident's physician of respiratory distress and continuous seizures for 1 of 3 sampled residents reviewed for notification of change (Resident #186) - see F 157 per the CMS-2567 for investigation details. F 157 was originally cited during the July 17, 2014 recertification survey as indicated in b. On 09/10/14 at 2:13 PM, an interview with the Director of Nursing (DON) in the presence of the	F 520	**F 520** **Corrective action for residents found to have been affected by this deficiency:** Resident #186 no longer resides at this facility. **Corrective action for residents that may be affected by this deficiency:** 1. A 100% audit was completed on 9/10/14 and again on 9/11/14 by the nurse management team (director of nursing, assistant director of nursing, 2 unit managers, wound nurse) a. The audit consisted of reviewing 100% of the nursing notes in the past 24 hours to ensure all residents experiencing any change of condition have had an appropriate nursing assessment and interventions, as indicated; physician notification for further guidance, as indicated and activation of EMS immediately, if indicated. 1. 2 residents were started on an antibiotic	

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F 520	Continued From page 36 Administrator revealed she was part of the quality assurance (QA) committee. The DON stated she was aware of the events that had taken place with Resident #186 and acknowledged she had read the nurse's note in its entirety dated 8/18/14, prior to the entry of the Recertification revisit/complaint survey. The DON stated after reading the nurse's note written by Nurse #1, she wondered why there was a time lapse from the point in which the resident was identified with oxygen saturation at 87 percent and the time the resident was sent to the hospital. She stated she had not identified any deficient concerns from the nurses notes nor had she conducted any interviews with the nursing staff (Nurse #1, Nurse #2), or that the staff needed to be re-trained. The DON elaborated there was no discussion in the last QA meeting held on 8/29/14, regarding needed care areas of improvement, surrounding the nurse's note dated 8/18/14. She further stated the event (Resident #186) was discussed on 8/19/14 at the morning team meeting but she did not call Nurse #1 or Nurse #2 in to talk to them regarding any problematic care concerns. The DON stated at the time, she did not see a quality assurance problem since the resident was discharged from the facility. The DON indicated "I saw the two hour time frame on the nurses' note but was not concerned because sometimes it takes EMS time to stabilize a resident. I thought the "gurgling" was due to seizure activity." The DON indicated during the QA committee meeting held on 8/29/14, there was no identified problems related to Resident #186, that needed to be systemically corrected related to continued seizures, respiratory distress or proper response and care in an emergency situation. The DON concluded the purpose of the QA is to identify problematic areas through chart review, nurses'	F 520	with appropriate physician notification 2. 2 residents had a fall with appropriate physician notification 3. 1 hospice resident expired with appropriate physician notification 4. No other concerns were identified 2. On 9/10/14 and 9/11/14, a facility nurse manager has been assigned to each unit observing all facility residents which reside on those units for any concerns and/or change in condition. 1. No concerns were identified in regards to physician notification. 3. The physician and/or his nurse practitioner are in the facility Monday – Friday and while in	

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F 520	Continued From page 37 notes, and clinical meetings and develop a QA plan for identified problems, with corrective measures and monitoring. On 9/11/14 at 10:52 am, in an interview, the Administrator stated she expected such a questionable concern (speaking of the nurse's note dated 8/18/14 written by Nurse #1) to have been brought to the Quality Assurance (QA) meeting for a team discussion and a plan initiated and implemented to ensure safe care of the residents and to prevent any reoccurrences. The administrator concluded after reviewing the nurse's note herself dated 8/14/14, she expected the concern to have been QA'd and a plan developed immediately, to educate the nursing staff and systems put in place for monitoring. The Administrator and the Director of Nursing were notified of the immediate jeopardy on 9/11/14 at 10:45 am. The immediate jeopardy was removed on 9/11/14 at 6:45 pm, when the facility provided an acceptable credible allegation that in part read: "Credible Allegation of Compliance: RESIDENT AT RISK 1. Resident #186 no longer resides at this facility. IDENTIFYING OTHER RESIDENTS AT RISK 1. A 100% audit was completed on 9/10/14 and again on 9/11/14 by the nurse management team (director of nursing, assistant director of nursing, 2 unit managers, wound nurse) 1. The audit consisted of reviewing 100% of the nursing notes in the past 24 hours to ensure all residents experiencing any change of condition	F 520	***Assurance Performance Improvement* (QAPI) Action Plan.** 2. The DON will submit all audits on physician notification and change of condition monthly to the QA to be reviewed and revised as needed. 3. The administrator will submit all audits on abuse and neglect allegations monthly to the QA to be reviewed and revised as indicated. 4. A QAPI Action Plan will be implemented whenever an issue is identified during AM Clinical Meeting and/or Department Head Meeting. 5. The QA Committee will review findings submitted by the different sub-committees to monitor continued compliance and opportunities for improvement. 6. The administrator and/or Clinical Resource Nurse will monitor the QA process weekly to ensure identified issues are monitored and revised to correct quality deficiencies. 7. **On 9/17/14 and 9/18/14 In-servicing for all facility staff was started on the following:** **a. Resident Protection System- Preventing**	

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F 520	Continued From page 38 have had an appropriate nursing assessment and interventions, as indicated; physician notification for further guidance, as indicated and activation of EMS immediately, if indicated. 1. 2 residents were started on an antibiotic with appropriate physician notification 2. 2 resident had a fall with appropriate physician notification 3. 1 hospice resident expired with appropriate physician notification 4. No other concerns were identified 2. On 9/10/14 and 9/11/14, a facility nurse manager has been assigned to each unit observing all facility residents which reside on those units for any concerns and or change in condition. 1. No concerns were identified in regards to MD notification. 3. The MD and/or his nurse practitioner are in the facility Monday - Friday and while in the facility staff will notify them there. When they are not in the facility then they will be contacted through the on-call service. MD notification is documented under the nursing charting in the medical record. 4. The MD is notified immediately in non-life threatening emergencies for further guidance and after EMS is activated in life threatening emergencies. 5. An abbreviated QA&A meeting will be conducted on 9/11/14 to address the identified concerns physician notification, change of condition (seizures, shortness of breath, change in level of consciousness to include unresponsiveness) from the follow-up survey (Revisit). PROCESSES IMPLEMENTED TO PREVENT FURTHER OCCURRANCES 1. To enhance current compliant operations and	F 520	the facility staff will notify them there. When they are not in the facility then they will be contacted through the on-call service. Physician notification is documented under the nursing charting in the medical record. 4. The physician is notified immediately in non-life threatening emergencies for further guidance and after EMS is activated in life threatening emergencies. 5. An abbreviated **Quality Assurance** (QA) meeting was conducted on 9/11/14 to address the identified concerns physician notification, change of condition (seizures, shortness of breath, change in level of consciousness to include unresponsiveness) from the follow-up survey (Revisit). **Measures that will be put into place to ensure that this deficiency does not recur:** 1. To enhance current compliant operations and under the direction of the administrator the Facility Department Heads will receive in-service training regarding the QA process on 9/11/14. **The in-service reviewed the QA Process Improvement and the *Quality***	

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F 520	Continued From page 39 under the direction of the administrator the Facility Department Heads will receive in-service training regarding the QA&A process on 9/11/14. 2. The DON will submit all audits on physician notification and change of condition monthly to the QA&A to be reviewed and revised as needed. 3. The administrator will submit all audits on abuse allegations monthly to the QA&A to be reviewed and revised as indicated. 4. A QAPI Action Plan will be implemented whenever an issue is identified during AM Clinical Meeting and/or Department Head Meeting. 5. The QA&A will review findings submitted by the different sub-committee to monitor continued compliance and opportunities for improvement. 6. The administrator and/or Apex Clinical Resource Nurse will monitor the QA&A process weekly to ensure identified issues are monitored and revised to correct quality deficiencies. The facility alleges the immediacy of these discrepancies have been abated on 9/11/14." On 9/11/14 at 6:45 pm, the credible allegation was validated. Staff interviews with licensed nurses and administrative staff revealed the facility had implemented corrective measures which included in-services of licensed nurses and administrative personnel regarding proper facility procedure and protocol for residents' experiencing seizures, respiratory distress, changes in levels of consciousness (LOC), emergency situations, physician notification, activation of emergency medical services and appropriate resident care during a seizure, respiratory distress, change in LOC or any emergency situation.	F 520	Abuse and Neglect b. Observation of Resident and Reporting Important Information About Their Care, Condition or Behavior c. What to Observe and Report d. When to Report e. Who to Report to f. Quality Assessment and Assurance. i. On 9/30/14 it was determined that all employees except one have received this in-service. This employee will not be allowed to return to work until the in-servicing is completed. ii. Any new employees hired will receive education regarding the items listed in	

7 a-f during the orientation process.

8. On 9/24/14, the Director of Quality Assurance and Compliance Officer from Apex HealthCare Solutions completed an in-service with the Administrator, Director of Nursing and other members of the Department Head Team regarding an effective QA committee and process, discussion included a meeting agenda and review of the Federal Regulatory Groups for Long Term Care facilities.
9. On 10/7/14 the QA Committee will be educated on the QA Program Plan. The QA Committee will follow the QA Program Plan going forward. QA tools discussed included but were not limited to the following: 1. QAPI Annual Reporting Schedule 2. Meeting Agenda 3. Quality Assurance Summary Report 4. QAPI Action Plan.
10. By 10/15/14 all nurses, nurse aides and certified nursing assistants will receive the directed in-service training for citations at 483.25 (a) and (h) (1-2) that involves transfer, ambulation and accidents or falls involving mobility problems by viewing the DVD

which has been approved by

The Division of Health Services Regulation.

11. On 10/15/14 a directed in-service will be completed for nurses, nurse aides and certified nursing assistants on identifying change in condition that requires emergency medical treatment and services. This directed in-service will be completed by a North Carolina Board Certified Internal Medicine Physician, with no affiliation to Carver Living Center or Apex HealthCare Solutions.

<u>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</u>

1. The Quality Assurance Committee will review facility progress monthly on the identified concerns.
2. Facility alleges compliance with this deficiency on 10/15/14.