

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

PRINTED: 11/20/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/23/2014
NAME OF PROVIDER OR SUPPLIER WILLOW CREEK NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534		
(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 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to develop a nursing care plan to address restorative passive range of motion services for 1of 2 residents, Resident #229, who was referred to restorative nursing services by the therapy department.</p> <p>A review of the Admission Minimum Data Set (MDS) Assessment dated 07/21/2014 revealed that Resident #229 was re-admitted to the facility on 07/14/2014 and had diagnoses which included cerebral vascular accident, hypertension, and hyperlipidemia. The same MDS revealed the</p>	F 279	<p>Willow Creek Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>Willow Creek Nursing and Rehabilitation <input type="checkbox"/>s response to this</p>	11/14/14	

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

TITLE

(X6) DATE

Electronically Signed

11/07/2014

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

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F 279	<p>Continued From page 1</p> <p>cognitive status of the resident was not assessed because the resident was not verbally responsive. The resident was totally dependent upon staff for bathing and eating, and also required extensive assistance for bed mobility, dressing, toilet use, and personal hygiene.</p> <p>A review of the nursing care plan revealed Resident #229 had multiple interventions in place to address her nursing care needs related to most of her diagnoses. There was no indication on the nursing care plan that goals and interventions were in place related to her need for restorative nursing services.</p> <p>The electronic Rehabilitation Communication to Nursing Services referral form was reviewed, and section A indicated that restorative services were to begin on 07/22/2014. Section C on the same form specified that passive range of motion exercise to the bilateral lower extremities (hips, knees, ankles) were needed to maintain range of motion within functional limits, and section E indicated that the frequency of the restorative exercises should be 5 times per week. The referral form was signed by physical therapy assistant (PTA) #1 on 07/16/2014.</p> <p>A review of the IDT care plan conference notes dated 08/05/2014 revealed there was no documentation to indicate the restorative services or passive range of motion was discussed.</p> <p>A review of all progress notes and assessments for Resident #299 dated 07/16/2014 through 10/22/2014 revealed there was no documentation to indicate the implementation of restorative nursing services or passive range of motion.</p>	F 279	<p>Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Willow Creek Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p> <p>F279 Resident #229 has been evaluated by both Physical Therapy on 10/29/14 to determine the most appropriate course of treatment at this time. Resident #229's care plan was updated to reflect Physical Therapy Plan of Care with the goal of preventing contractures, improving bed mobility and comfort on 11/4/14 by the MDS Nurse.</p> <p>To ensure that all residents, including resident #229, included in restorative programming have Care Plans in place for services being provided, a 100% audit was completed on 11/4/14 by the MDS Nurse. For each, including resident #229, Care Plans were reviewed and updated to reflect most current information completed by 11/7/14 by the MDS Nurses.</p> <p>Nursing staff, MDS Nurses and Rehab Staff have been in-serviced on the new guidelines for referral to Restorative Services including communication, expectations, and proper Care Planning. These in-services will be completed by the</p>		

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F 279	<p>Continued From page 2</p> <p>In an interview with the Restorative Nurse on 10/23/2014 at 1:35 PM, she stated she did not recall Resident #229 ever receiving restorative nursing services since the beginning of her current admission. The Restorative Nurse then searched the resident ' s medical record for the interdisciplinary (IDT) care plan regarding restorative services and found there was no such care plan present. She stated that typically, the therapy department would enter any referrals for restorative services in the computer, and that as a Restorative Nurse, she would review the referral, write a care plan to address restorative services for the resident, and then implement the restorative services.</p> <p>In a second interview with the Restorative Nurse in the presence of the Rehabilitation Department Coordinator on 10/23/14 at 2:10 PM, the Restorative Nurse agreed there was no documentation in the resident ' s chart to indicate that the referral was received, care planned, or implemented. The Restorative nurse stated she thought she remembered discussing range of motion restorative services for Resident #229 in the last interdisciplinary care plan meeting which was on 08/05/2014. The Rehabilitation Department Coordinator stated there could be a problem with communication between the nursing and therapy departments which needed to be improved so that restorative care and care planning could be properly implemented.</p> <p>In an interview with the Administrator on 10/23/14 at 4:00 PM, she stated it was her expectation that all restorative referrals from the therapy department should be reviewed by the Restorative Nurse, and that the restorative nursing department should use tools to determine</p>	F 279	<p>Administrator and Restorative Nurse by 11/12/14.</p> <p>To assure continued compliance with this corrective action, the DON/ ADON will review the current Restorative Caseload on a weekly basis for changes in services and, additionally, review all Rehab to Nursing Communication Forms to assure all residents, including resident #229, who are referred to restorative nursing are appropriately addressed. This includes inclusion in appropriate Restorative Programs, completion of Care Plans, and/or implementation of other recommended interventions. This audit process will be completed weekly beginning on 11/7/14 and continue weekly X 4 weeks then bi-weekly X 3 months.</p> <p>All data will be submitted to the Quality Improvement Executive Committee for review and recommendations monthly X 6 months then quarterly thereafter. This corrective action will be fully implemented by November 14, 2014.</p>		

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F 279	Continued From page 3 the resident ' s needs in order to implement the appropriate restorative services. She also indicated that the Restorative Nurse should discuss the need for restorative services with the interdisciplinary team and that a care plan should be written as part of the coordination of restorative services.	F 279			
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, 1) the facility failed to initiate restorative nursing services as recommended in a referral by the therapy department for 1 of 2 residents, Resident #229, who were reviewed for restorative nursing services, and, 2) the therapy department failed to enter a request for recommended restorative ambulation services into the electronic medical record system for 1 of 2 residents, Resident #67, reviewed for rehabilitation services. Findings included: 1. A review of the Admission Minimum Data Set (MDS) Assessment dated 07/21/2014 revealed that Resident #229 was re-admitted to the facility on 07/14/2014 and had diagnoses which included, but were not limited to, cerebral	F 318	F318 Resident #229 was evaluated by Physical Therapy on 10/29/14 to determine appropriate treatment at this time and has been added to PT caseload for contracture management, bed mobility and comfort. Resident #67 has been evaluated by Occupational Therapy on 10/28/14 and Physical Therapy on 10/30/14. #67 will be receiving PT for ambulation and OT for contracture management. To ensure that all resident, including resident #229 and #67, intended by PT/OT/ST to be included in restorative programming have been referred, and	11/14/14	

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F 318	<p>Continued From page 4</p> <p>vascular accident, hypertension, and hyperlipidemia. The resident was totally dependent upon staff for bathing and eating, and also required extensive assistance for bed mobility, dressing, toilet use, and personal hygiene.</p> <p>A review of the nursing care plan revealed Resident #229 had interventions in place to address her nursing care needs related to most of her diagnoses. There was no indication on the nursing care plan that interventions were in place related to her need for restorative nursing services.</p> <p>A review of the Physical Therapy Discharge Summary dated 07/21/2014 revealed Resident #229 received physical therapy (PT) services beginning on 07/14/2014, and that the short term goal for therapy was as follows: "Pt. (patient) will be able (to) maintain rom (range of motion) within functional limits with referral to restorative department." Further review of the same discharge summary indicated that the resident needed total assistance and was in a vegetative state. In addition, the summary revealed that the skilled services provided by the PT department included therapeutic exercises and Restorative training.</p> <p>The electronic Rehabilitation Communication to Nursing Services referral form was reviewed, and section A indicated that restorative services were to begin on 07/22/2014. Section C on the same form specified that passive range of motion exercise to the bilateral lower extremities (hips, knees, ankles) were needed to maintain range of motion within functional limits, and section E indicated that the frequency of the restorative</p>	F 318	<p>that services for which they were referred have been implemented, 100% audit of six months of Rehab Communication to Nursing forms has been completed by QI Nurse on 10/30/14. Current Restorative caseload has been compared to referrals made by Rehab, the modalities requested have been matched and a review of current progress against Rehab expectations has been completed on 10/30/14 by QI Nurse and Administrator. Appropriate recommendations have been made back to Therapy for all identified areas on concern on 10/31/14.</p> <p>In-service with Therapies, MDS nurses, Restorative Nurse and QI nurse has been completed on 11/7/2014 to assure proper communication and establish guidelines for inclusion in Restorative Programming and the requirement for a Restorative Care Plan for each by 11/12/14.</p> <p>A rehab communication to nursing form will be completed in the electronic record and printed for paper documentation, for all residents referred to restorative programming by Therapy to Administrator and ADON upon completion by the therapy department. The Restorative Nurse will ensure that the restorative referral has been completed in the electronic medical record; restorative programming has been initiated timely per the referral and care plan updated to reflect the restorative programming utilizing a restorative QI Audit tool weekly x 4 weeks beginning the week ending 11/7/14. All identified areas of concern will</p>		

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F 318	<p>Continued From page 5</p> <p>exercises should be 5 times per week. The referral form was signed by physical therapy assistant (PTA) #1 on 07/16/2014.</p> <p>A review of the resident's progress notes and assessments dated 07/16/2014 through 10/22/2014 revealed there was no documentation to indicate the implementation restorative nursing services.</p> <p>In an observation made on 10/22/2014 at 3:32 PM, the Resident #229 was lying on her right side with her eyes closed. The resident did not respond to verbal stimuli. A pillow was noted between her legs which were flexed at the knees in a 90 degree angle.</p> <p>In an observation on 10/23/2014 at 11:50 AM, Resident #229 was lying in bed, shifted to her left side, with her knees flexed at a 90 degree angle and a pillow between her legs. The resident had her eyes partially open, but did not respond verbally or by any gesture.</p> <p>In an interview with the Restorative Nurse on 10/23/2014 at 1:35 PM, she stated she did not recall Resident #229 ever receiving restorative nursing services since the beginning of her current admission. The Restorative Nurse then checked the resident's medical record for any documentation regarding restorative services and did not find any such documentation. She stated that typically, the therapy department would enter any referrals for restorative services in the computer, and that as a Restorative Nurse, she would review the computer for referrals, usually on a daily basis. She also stated that she would initiate a care plan regarding restorative services for the resident and then implement the</p>	F 318	<p>be immediately addressed by the Restorative Nurse. The Administrator and DON will review the restorative QI audit tool weekly X 4 weeks, bi weekly X 4 weeks, and monthly thereafter, for completion and to address any discrepancies.</p> <p>The restorative QI audit tools will be presented to the Quality Improvement Executive Committee on a monthly basis X 6 then a quarterly basis ongoing to ensure the program remains compliant and responsive to the needs of the residents.</p> <p>This corrective action will be fully implemented by November 14th, 2014.</p>		

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F 318	<p>Continued From page 6 restorative services.</p> <p>In an interview with the Rehabilitation Department Coordinator on (RDC) 10/23/2014 at 1:52 PM, she stated the process for making a referral from PT to Restorative Nursing began with the therapist filling out the referral form, then entering the form into the electronic charting system. She explained that the PT department would also train the restorative nurse aide, and that the Restorative Nursing Department would then review the referral and implement the restorative services. The RDC then located the referral form dated 07/16/2014 for Resident #229 in the computer and printed a copy.</p> <p>In a second interview with the Restorative Nurse in the presence of the RDC on 10/23/14 at 2:10 PM, the Restorative Nurse stated she could not remember what she did with the referral from PT, and she agreed there was no documentation in the resident ' s chart to indicate that the referral was received or implemented.</p> <p>In an interview with the Administrator on 10/23/14 at 4:00 PM, she stated it was her expectation that all restorative referrals from the Therapy department should be reviewed by the Restorative Nurse, and that the restorative nursing department should use tools to determine the resident ' s needs to implement the appropriate restorative services. She also indicated that this process should be documented and care planned as appropriate.</p>	F 318			

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F 318	<p>Continued From page 7</p> <p>2. Resident # 67 was admitted to the facility on 10/3/13 with diagnoses including dementia, cerebral artery occlusion with infarct (CVA), hemiplegia due to cerebral vascular disease (CVA).</p> <p>Resident # 67's annual minimum data set (MDS) dated 08/19/14 revealed a Brief Interview for Mental Status (BIMS) summary score of 14, which is cognitively intact. Her physical therapy (PT) ended 08/19/14, and restorative nursing program was not checked. Functional status revealed the resident needed extensive assistance with: bed mobility, transfers, walking, locomotion, dressing, toilet use, and personal hygiene. She needed total assistance with bathing, and supervision with eating. Resident # 67 had impairment on the right side and used a walker and wheelchair.</p> <p>The PT progress and discharge summary dated 08/26/14 revealed resident # 67 was on the PT case load from 05/16/14 to 08/26/14. Start of goal status for ambulation as of 06/10/14 revealed resident # 67 was unable to ambulate at that time. End of goal status for ambulation as of 08/26/14 revealed Resident # 67 had met the goal for gait ability with a wide based quad cane on even surfaces and that she required minimal assistance. The discharge plans and instructions from the therapy department were for restorative ambulation to be performed as per patient willingness to perform the task.</p> <p>Staff interview on 10/23/14 at 1:46 PM with the PT Program Director revealed that it was her expectation that the physical therapist would enter the request for resident # 67's restorative ambulation into the "Point and Click" electronic</p>	F 318			

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F 318	<p>Continued From page 8</p> <p>system, and for restorative nursing to pick-up the request and place the resident on the restorative case load.</p> <p>Staff interview with the Administrator and Director of Nursing (DON) on 10/23/14 at 3:05 PM revealed that it was their expectation that PT would notify restorative nursing of a referral by the electronic system. In addition, they stated that the request was not made by PT in this case, so restorative nursing did not initiate ambulatory therapy as recommended.</p> <p>Resident observation on 10/23/14 at 9:30 AM revealed resident # 67 in bed, with a pillow propping against the right side of her head, with the head of bed elevated. At 4:40 PM the resident was observed sitting in a chair by the side of her bed.</p> <p>Staff interview with Nurse #1 on 10/23/14 at 9:32 AM revealed resident # 67 had a rolled up washcloth in her right hand, with no splint order, and had right hemiplegic diagnosis that was added to the medication administration record (MAR) list of 08/19/14. The nurse said it was the first time in a month or so that they had put resident # 67 in her chair, and that she was surprised that they actually put her in her Broda chair on 10/22/14. Resident # 67 said it was the first time in a long time that they had put her in her bedside chair, and that she liked the chair because she could lean back in it.</p> <p>Resident interview with resident # 67 on 10/23/14 at 3:32 PM who stated she would have liked to get up and walk more. She said PT walked her a couple of times in the past, and she did good. She also said since she discontinued PT, the</p>	F 318			

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F 318	Continued From page 9 nursing aides had not walked her at all.	F 318		